ICBA BENEFITS

Organic BC
Group Benefits Program
Participating Employer Application Form

Requested Effective Date
(mm/dd/yyyy)
_____

Organization information

Legal name of organization	DBA (if different than legal name)	
Nature of Business	Number of Years in Business	○ Corporation ○ Partnership ○ Sole Proprietorship

Subsidiary/Affiliated Companies (List subsidiary or affiliated companies whose employees you are requesting to be covered under this application.)

Address	City	Province	Postal Code
Name of Authorized Signing officer	Phone	Email	
Name of Plan Administrator (if different)	Phone	Email	
Plan Advisor (Agent) Name	Company (Agency name)		

Employee information

Total number of employees on payroll: Full-time: Part-time:	Number of eligible employees (employees working 20+ hours/week):
Do all employees receive T4's? ○ Yes ○ No- explain:	
Are any employees away from work due to sickness or injury? ○ Yes. Complete Page 4, List of Employees Not Actively At Work. ○ No	

Other Information

Current Plan Information
○ No current plan in place
○ Current plan provided by (name of insurance company) _____, policy number _____
Benefits covered: ❑ Life/AD&D ❑ Dep Life ❑ CI ❑ WI/STD ❑ LTD ❑ EHC ❑ Dental ❑Other: _____
Provide copy of your most recent invoice with this Application so that coverage levels can be grandfathered where applicable.

Payment and Invoicing
Payment method ○ Cheque ○ Pre-authorized payment (Submit Pre-Authorized Payment Agreement with this Application.)
Monthly invoice: ○ Paperless – invoices will be available online ○ Mail our invoice

Deposit
❑ Our cheque in the amount of $_____ representing the estimated first month's premium is attached.
If the application is accepted, this payment will be credited to our account; otherwise it will be returned. Initial:

Payment Terms Payment is due on the first of every month for that month's premiums. If payment is late, claims payment will be suspended, and the plan will be cancelled if payment is outstanding for 60 days.	
Participation All employees eligible are required to join the plan. Employees may waive EHC and/or Dental coverage if they have coverage through a spouse's plan for these benefits.	
Plan Renewal This plan is part of a pool that renews annually based on the experience of the pool as a whole. If your plan becomes effective within 9 months of the renewal date, your rates will remain the same until the following renewal. Your plan's individual experience will not be available.	
Plan Termination You may terminate this plan on the last day of any month by providing 31 days written notice to ICBA Benefit Services Ltd.	
Plan Administration This plan will be administered by ICBA Benefit Services Ltd. in accordance with the terms and conditions of the policy(ies), and the ICBA Benefits Administration Guide, a copy of which, along with updates that will issued from time to time, will be provided to you.	

Employee Class		Minimum hours worked per week [1]	Option	Waiting Period Apply to: ○ current employees ○ future hires only	
				# Months[2]	Start on 1st[3]
1	○ All employees ○ Other – specify:		○ Bronze ○ Silver ○ Gold		○ Yes ○ No
2			○ Bronze ○ Silver ○ Gold		○ Yes ○ No
3			○ Bronze ○ Silver ○ Gold		○ Yes ○ No
4			○ Bronze ○ Silver ○ Gold		○ Yes ○ No

Employer Contribution to Premiums (minimum required: 50% overall)

○ 100% paid by employer

○ 50/50 premium split. Employee's portion goes towards Life/AD&D, Dep Life, STD and LTD first, with balance to other benefits.

○ As indicated:

Benefit	Employer Contribution	Benefit	Employer Contribution
Life / Accidental Death & Dismemberment	%	Extended Health	%
Dependent Life	%	Dental	%
Critical Illness	%	Employee Assistance Program	%
Weekly Indemnity	%	Other:	%
Long Term Disability	%		%

I confirm that the statements and answers contained in this document are full, complete and true, and understand that they constitute the application for and form part of the contract. I understand that the insurance will become effective on the requested effective date if approved by the insurance company(ies) underwriting these benefits.

Dated at _____ this ____ day of _____, 20__.

Authorized signing officer

[1] Employees must work at least 20 hours per week to be eligible under this plan.

[2] For coverage that starts on the date of hire, or on the first of the month following date of hire, indicate 0.

[3] Indicate Yes if coverage starts on the first of the month following/coincident with the waiting period; otherwise indicate No.

Group Benefits Plan
Pre-Authorized Debit Agreement

	Name of Organization:

Authorization	Note: References in the PAD agreement to "this PAD agreement" include later amendments to it. Reference in this PAD agreement to "we" and "our" refers to the policyholder (payor). We authorize ICBA Benefit Services Ltd. (ICBA Benefits) and the financial institution named above (or any other financial institution we may authorize at any time) to withdraw from our account any payments that we have agreed to make under the policy listed above, and/or as otherwise specified to us made in the PAD agreement as though we had personally signed a cheque. We understand that changes to the policy, including as applicable, to premium amounts or to the method or required amount of payment (including changes requested to this PAD agreement) or termination and recommencement of automatic payments under this PAD agreement may increase or decrease the amount withdrawn or to be withdrawn from our account. Accordingly, we authorize such increases or decreases, waiving any pre-notification requirement with respect to them. We agree that a photocopy or electronic copy of the PAD agreement will be as valid as the original.
Signatures	We certify that all persons whose signatures are required to authorize this PAD agreement have signed below, including any required joint account holder.
Account changes	We will notify ICBA Benefits if our financial institution, transit (branch) or account number changes. To continue withdrawals without interruption, notice of any change is required 14 days before the change effective date. ICBA Benefits may, but is not obligated to, rely on verbal instructions from us to amend this authorization.
Confirming withdrawals	We agree to regularly review our account information and if we question or disagree with the amount withdrawn or any account changes, we will notify ICBA Benefits in writing within 10 days of the withdrawal or account changes; otherwise, we agree that the withdrawal or account changes will be considered to have been properly made.
Non-sufficient funds (NSF) information	If funds in our account are not sufficient to cover the total amount due ("due" as an amount owing, or an amount otherwise specified to be withdrawn under this PAD agreement), we authorize ICBA Benefits to immediately make a second attempt to withdraw the amount due (which may be greater than the amount due at the first attempt). We understand that we are responsible for any NSF charge(s). We understand that our claims payments will be suspended if our payment is NSF, and our policy will be terminated if payments are NSF for two consecutive months' premiums.
Assignment	We hereby waive any requirement of prior written notice to us by ICBA Benefits of the assignment of ICBA Benefits of this PAD agreement.
Cancellation	This PAD agreement may be cancelled if any withdrawal is not permitted or is reversed by the financial institution, or upon 30 days written notice given by us to ICBA Benefits, or by ICBA Benefits to us.
Recourse	We have certain recourse rights if any debit does not comply with this PAD agreement. For example, we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on our recourse rights, we can contact our financial institution or visit www.cdnpay.ca.

◯ Void cheque attached ◯ Direct deposit form from financial institution attached ◯ Bank account details provided below

Name of Institution:	Branch Address:	
Institution No.	Transit (branch) No.	Account No.

Name of Authorized Person or 1st Accountholder Name:	Name of Authorized Person or 2nd Accountholder Name:
Date signed (mm/dd/yyyy):	Date signed (mm/dd/yyyy):
Signature	Signature

Submit this Authorization, along with a void cheque or direct deposit form (if applicable), and your Participating Employer Application form.

List of Employees Not Actively At Work

Legal name of organization

	Employee Name	Last Day Worked (mm/dd/yyyy)	Reason for Absence	Expected return to work (mm/dd/yyyy) [1]	Approved for Life Waiver of Premium [2]
1					☐ Yes ☐ No ☐ N/A
2					☐ Yes ☐ No ☐ N/A
3					☐ Yes ☐ No ☐ N/A
4					☐ Yes ☐ No ☐ N/A
5					☐ Yes ☐ No ☐ N/A
6					☐ Yes ☐ No ☐ N/A
7					☐ Yes ☐ No ☐ N/A
8					☐ Yes ☐ No ☐ N/A
9					☐ Yes ☐ No ☐ N/A
10					☐ Yes ☐ No ☐ N/A

ORGANIC BC
PLAN DESIGN

	Bronze	Silver	Gold
CORE BENEFITS			
BASIC LIFE INSURANCE – Desjardins Policy #647222			
Benefit Amount (flat benefit)	Flat $25,000	Flat $25,000	Flat $25,000
Waiver of Premium	Yes	Yes	Yes
Conversion Privilege	Yes	Yes	Yes
Living Benefit	Yes	Yes	Yes
Reduction Schedule	Reduce by 50% at 65	Reduce by 50% at 65	Reduce by 50% at 65
Termination Age	70	70	70
ACCIDENTAL DEATH & DISMEMBERMENT – Industrial Alliance Policy #100008828			
Benefit Schedule (flat benefit)	Flat $25,000	Flat $25,000	Flat $25,000
Waiver of Premium	Yes	Yes	Yes
Aggregate Limit	$5,000,000	$5,000,000	$5,000,000
Conversion Privilege	Yes	Yes	Yes
Reduction Schedule	Reduce by 50% at Age 65	Reduce by 50% at Age 65	Reduce by 50% at Age 65
Termination Age	70	70	70
EXTENDED HEALTH CARE – Green Shield Policy #BSL1-244			
Annual Deductible	$50 Single/ $100 Family	$50 Single/ $100 Family	Nil
Out of Province Emergency Medical	100% up to $5,000,000 60 day Trip Limit	100% up to $5,000,000 60 day Trip Limit	100% up to $5,000,000 60 day Trip Limit
All Other Benefits	70%	80%	100%
Prescription Drugs • Mandatory Generic • Pay-Direct Drug Card	Included	Included	Included
Paramedical Services • Acupuncturist • Chiropodist/Podiatrist • Chiropractor • Clinical Counsellor/Psychologist • Massage Therapist • Naturopath • Osteopath • Physiotherapist • Speech Therapist	$350 per year per practitioner type	$500 per year per practitioner type	$500 per year per practitioner type
Accidental Dental	Within 12 months of accident	Within 12 months of accident	Within 12 months of accident
Hospital Room	Private & Semi-Private	Private & Semi-Private	Private & Semi-Private
Ambulance	Covered	Covered	Covered

	Bronze	Silver	Gold
Hearing Aids	$500 every 5 years	$500 every 5 years	$500 every 5 years
Private Duty Nursing	$10,000 per year	$10,000 per year	$10,000 per year
Orthopedic Shoes	$500 per adult per year $300 per child per year	$500 per adult per year $300 per child per year	$500 per adult per year $300 per child per year
Orthotics	$400 every 2 years	$400 every 2 years	$400 every 2 years
Medical Equipment, Aids & Supplies	Reasonable & Customary	Reasonable & Customary	Reasonable & Customary
Vision Care	Not Included	Not Included	Adults: $100 every 2 years Children: $100 every year
Eye Exams	Not Included	Not Included	Adults: $75 every 2 years Children: $75 every year
Termination Age	Earlier of 85 or retirement	Earlier of 85 or retirement	Earlier of 85 or retirement
DENTAL CARE – Green Shield, BSL1-244			
Deductibles	Nil	Nil	Nil
Basic	70% up to $750 per calendar year	80% up to $1,000 per calendar year	100% up to $1,500 per calendar year
Major	Not covered	Not covered	Not covered
Orthodontia	Not covered	Not covered	Not covered
Recall Exams	Twice per calendar year	Twice per calendar year	Twice per calendar year
Annual scaling	16 units per calendar year	16 units per calendar year	16 units per calendar year
Termination Age	Earlier of 85 or retirement	Earlier of 85 or retirement	Earlier of 85 or retirement
EMPLOYEE ASSISTANCE PROGRAM HumanaCare	Included	Included	Included
MONTHLY COST (Effective July 1,2023)			
Single	$128.81	$136.81	$208.43
Couple	$246.23	$231.76	$412.50
Family	$326.32	$350.61	$561.63
OPTIONAL BENEFITS			
Optional Critical Illness Protection	Units $25K to $100 K max. No medical exam is required, If applied for within 30 days of becoming eligible		
Optional Life Coverage	Units of $10K to lesser of 5X salary or $500,000. **Medical exam required for this benefit.**		
Optional AD&D	Units of $10K to lesser of 5X salary or $500,000. **Medical exam required for this benefit.**		
Health Spending Account	Available		
Group RRSP and/or TFSA Plan	Available		

To complete and e-sign this form online, please open it in Adobe

Group Benefits
Employee Enrolment Form

For ICBA Benefits Use:
Certificate Number: _____
Effective Date (m/d/y): _____

Section 1 – Plan Sponsor / Employer complete this section

Note: Please see pages 3 & 4 for Instructions and Additional Information

Organization/Company	***Client Code***	***Policy No.***	***Billing Group No.***	***Class Code***

Employee Last name	Employee First Name	Check One: ○ New Application ○ Reinstatement
Date of Employment (mm/dd/yyyy)	Occupation	Regular hours worked per week

Salary _____ Per: ○ Year ○ Month ○ Week ○ Hour	Is this a ***Late Application***? ○ No ○ Yes - ***Evidence of insurability form*** is attached ○ Yes - ***Evidence of insurability form*** will follow

○ Apply plan waiting period
○ Waive waiting period (additional information may be required – contact us to find out your plan's requirements.)

Your Name and Title	Email address	Phone No.
Date signed (mm/dd/yyyy)	Signature	

Section 2 – Employee complete this section

Date of birth (mm/dd/yyyy)	***Gender*** (X denotes non-binary) ○ Male ○ Female ○ X	***Do you have a spouse?*** ○ Yes ○ No For common-law, date of cohabitation:_____ (mm/dd/yyyy)

Email address	Daytime phone number	***Do you have dependent children***: ○ Yes ○ No	
Home address (number, street, suite #)	City	Province	Postal Code

Coverage selected **Health**: ❑ Single ❑ Family ❑ Waive* **Dental**: ❑ Single ❑ Family ❑ Waive*
**Waive denotes coverage through spouse's plan*

Coordination of Benefits Information - complete to coordinate benefits with your spouse's plan, if applicable

Insurance Company	Policy/Group No.	Type of coverage: ❑ Health ❑ Dental	Cardholder: ○ My spouse ○ ***Other:***	Coverage ○ Single ○ Family

Dependent Information **– complete if you have a spouse/eligible children, even if you are waiving coverage for them, if applicable**

Note: If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

❑ More than 5 children, attach list

	Last Name	**First Name**	**Date of Birth (mm/dd/yyyy)**	***Gender*** *(X denotes other/non-binary)*	***If over 21:***
Spouse				○ Male ○ X ○ Female	n/a
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled
Child				○ Male ○ X ○ Female	❑ Full-time Student ❑ Disabled

Section 3 – Employee complete this section

Beneficiary Designation for Basic Life and Basic Accidental Death insurance:

Primary Beneficiary(ies)

	Name	Date of Birth (mm/dd/yyyy)	Relationship to You	*Type* Important: See note below	Percentage
1	Last name First name Initial			○ Revocable ○ Irrevocable	%
2	Last name First name Initial			○ Revocable ○ Irrevocable	%
3	Last name First name Initial			○ Revocable ○ Irrevocable	%
4	Last name First name Initial			○ Revocable ○ Irrevocable	%

If you designate a beneficiary, primary or contingent, as irrevocable, that person's consent is required if you later want to change your beneficiary. A minor child cannot give consent, therefore if you designate a minor child as irrevocable, you will not be able to change your beneficiary until the child reaches the age of majority and consents to the change.
The percentages must total 100%. If percentage is left blank, insurance will be split evenly among the beneficiary(ies). If you want to designate more than 4 primary beneficiaries, complete Beneficiary Designation form. If you do not designate a beneficiary, proceeds will be paid to your estate.

***Trustee* (Complete if any beneficiary is under the age of majority. Please indicate full legal name in appointment below)**

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority.

	Contingent Beneficiary	Date of Birth (mm/dd/yyyy)	Relationship to you	Type Imporant: See note above
1	Last name First name Initial			○ Revocable ○ Irrevocable

Section 4 – Employee complete this section

Protecting your personal information

ICBA Benefits is committed to protecting the privacy, confidentiality, accuracy and security of your personal information. Your personal information, and the personal information of your spouse and dependents, if applicable, will be collected and used by us to determine your eligibility for group benefits coverage, to administer the group benefits plan, to assess benefits and insurance claims and for other purposes described in our Privacy Policy, which is available at icbabenefits.ca. Access to personal information is limited to authorized employees and contractors of ICBA Benefits who require it to perform their duties, to those persons that you have granted access (such as your spouse or employer) and to other persons authorized by law.

Personal information may also be shared with third parties that help us administer the group benefits plan, such as insurance companies and their reinsurers, your employer, health services providers, administrators of government benefits or other benefits programs and our technology partners, including for the purposes of verifying eligibility for specific benefits or claims, processing payments and investigating or reporting suspected or apparent fraudulent or suspicious claims behaviour.

For more information about our privacy practices and procedures, please see our Privacy Policy or contact our Privacy Officer at privacy@icbabenefits.ca.

Declaration and authorization

I hereby apply for coverage under this policy, and accept its terms and conditions. I authorize the necessary contributions to be made through payroll deductions, if applicable.

I have read, understand and agree with the section above entitled "Protecting your personal information" and hereby consent to the collection, use and disclosure of my personal information as described in this form and ICBA Benefits' Privacy Policy. If I have provided the personal information of my spouse or any dependents, I hereby confirm that I am authorized to act on their behalf.

I understand that I am responsible for the accuracy of all claims submitted on behalf of myself, my spouse and/or my dependents, and that my eligibility and/or entitlement to any or all benefits under the Plan may be suspended and/or revoked without notice in the event that I, my spouse or any dependents am found to have made fraudulent or repeated inaccurate claims under the plan. Further, I hereby authorize my employer to deduct from my payroll and remit to the plan any amounts paid to me as a result of fraudulent or inaccurate claims by myself, my spouse or my dependents.

I certify that I am covered, and my spouse and dependents (if applying for coverage) are covered by a provincial medical plan, e.g. Medical Services Plan of BC.

I certify that all of the information I have provided on this form is true, correct and complete to the best of my knowledge.

Signature:	Date Signed (mm/dd/yyyy):

Return completed form to ICBA Benefits via email (for active groups, indicate your policy number in the email subject line), or by mail. If you email the form, you are not required to send the original by mail.

ICBA Benefit Services Ltd. | Email: info@icbabenefits.ca | Mailing Address: 700-4730 Kingsway, Burnaby, B.C. V5H 0C6

Instructions/Additional Information:

Billing Group No. – Provide only if the plan has multiple divisions or billing groups; otherwise leave blank. If applicable, the number will appear on your monthly invoice.

Class Code – Provide only if your plan includes a class number; otherwise leave blank.

Client Code – Indicate either number as it appears on your monthly invoice.

Contingent Beneficiary – If all the primary beneficiaries should die before you, proceeds will be paid to a contingent beneficiary. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Coordination of Benefits information – This information is required to establish which plan is primary and which plan is secondary for Health and Dental claims. If you are waiving coverage for yourself/your dependents, some carriers require that you provide this information as proof of other coverage.
Note: If you are applying for Health and/or Dental after having previously waived coverage, or if you are enrolled for Health and/or Dental and now want to waive coverage, complete our Amendment to Coverage Status form.

Date of employment – Indicate the date the employee began working 20 hours per week on a regular basis, not including overtime. Usually, this will be the original date of hire; however if the employee was hired on a casual basis, or on a part-time basis working less than 20 hours per week on average, enter the date employment changed to 20 hours/week. If this is a reinstatement, enter the date of rehire.

Dependent Information – complete this section if you have a spouse/eligible children, even if you are waiving coverage for them. If you are waiving Health and Dental coverage for your spouse/children, we need to know who your dependants are for two reasons: (1) in the event we later receive an enrolment request for them, and (2) your plan may include Dependent Life insurance. If you have more than 5 children, attach list with required information for the additional child(ren).

Do you have a spouse? – Indicate Yes if you are legally married or living in a common-law relationship.

Do you have dependent children? – Indicate Yes if you have a child(ren) under age 21, or a full-time student age 21-25, or a disabled child over age 21. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Evidence of Insurability Form – Contact us for the form.

Gender – Please indicate the gender per your government issued ID. For non-binary, indicate "X". Note: the insurance company may require a gender of male or female for underwriting purposes.

If over 21 - To be covered on your plan beyond age 21, a child must either meet Canada Revenue Agency's criteria for a full-time student, or be disabled. If your child is disabled, additional information is required to approve coverage beyond the plan's age limits. Contact us for more information.

Do not return this page to ICBA Benefits.

Late Application – If we receive this application more than 31 days after the employee is first eligible for coverage, it is considered late and ***evidence of insurability*** in the form of a completed health questionnaire is required. The insurance company may decline to cover the applicant(s). If the application is approved, coverage will begin as applicable, and Dental coverage will be restricted for the first 12 months of coverage. Contact us for the required form. The completed form can be scanned and emailed to us, or mailed. For confidentiality purposes, we suggest that the employee submit the form to us directly, or provide to you in a sealed envelope for mailing to us.

Other – Examples of Other plans, i.e. where the cardholder is not your spouse, include coverage you have through another employer or retiree plan. Please note, not all insurance companies will accept waivers/applications related to other coverage that is not a spouse's plan. We will let you know if your application / waiver is not accepted by the insurance company.

Reinstatement – If the employee previously had coverage under the plan and coverage terminated more than 6 months from the date of rehire, the plan waiting period will be applied to the date of rehire (unless there is written indication that the the Plan Sponsor/Employer is waiving the waiting period). If the previous coverage terminated less than 6 months from the date of rehire, coverage starts on the date of rehire. Note, both situations are subject to **late application** rules.

Trustee - Designate a trustee for any beneficiary who is younger than the age of majority in your province.

Type (Beneficiary Designation) – If you designate a beneficiary as Irrevocable, you cannot change your beneficiary designation without that person's consent. Important note: If you designate a minor child as your Irrevocable beneficiary, the child cannot consent to a change in beneficiary until they reach the age of majority. If you designate your beneficiary as Revocable, you may change your beneficiary designation at any time without restriction.

Waiving Health and/or Dental – Coverage under the plan is mandatory, except if the employee or dependents are covered under another plan for Health and/or Dental benefits. You may waive coverage for yourself or for yourself and your dependents if you/they are covered for Health and/or Dental benefits under another plan. Note that you/ they can only join the plan in future if the other plan terminates, and time limits apply.

Do not return this page to ICBA Benefits.