Sirius Benefits
Sirius Benefits is a People Corporation Company

ATCMA
ASSOCIATION OF TRADITIONAL CHINESE MEDICINE AND ACUPUNCTURE OF BC

Small Group Application

Please print the information on this form and complete each section in full. Incomplete submissions may create delays in issuing this Group.

A. Policyholder

Full Legal Name _____

Mailing Address _____

City _____ Province _____ Postal Code _____

Telephone # _____ Fax # _____

Nature of Business _____

☐ Corporation ☐ Proprietorship ☐ Partnership ☐ Other _____

Affiliates / Subsidiaries _____

Name of Business Association (If applicable) _____

Plan Administrator Name _____ Email _____

B. Requested Effective Date _____

C. Waiting Period (applies to all new hires) ☐ 90 days (minimum) ☐ 180 days ☐ Other: _____

D. Rating Information **(see Declaration section for further detail on enrolment requirements)**

Number of eligible employees _____ Number of employees enrolling on the plan _____

Number of ineligible employees (part-time) _____

E. Premium Payment and Billing

Initial Premium enclosed $ _____ (cheque cannot be post-dated)

Payment and Billing Method

☐ pre-authorized payment* and electronic billing (via email) - attach a copy of a void cheque

provide the email address to be used _____

☐ monthly cheque and electronic billing (via email)

provide the email address to be used _____

There is a $5.00 per month charge applied to your billing if you chose one of these options

☐ pre-authorized payment* and paper billing - attach a copy of a void cheque

☐ monthly cheque and paper billing

* Pre-authorized payments are deducted on the 1st of each month

F. Eligibility Questions

1. Is this plan replacing an existing group plan? ☐ Yes ☐ No
   - If yes, identify how long the insurance has been inforce.
   - List the underwriting/insuring company
   - Please attach a copy of the most recent billing statement

2. Has the firm been in operation for more than 6 months? ☐ Yes ☐ No
   - If yes, advise when firm started operations
   - If no, contact Head Office Sales & Marketing for approval prior to submitting

3. Is the firm in active operation 12 months of the year? ☐ Yes ☐ No
   - If no, advise when it is inactive
   - If no, advise what the employees are paid during this time (full or partial wage, laid off)

4. Have you or any of your employees ever applied for or been insured under a program administered by Associations Comprehensive Benefits Program or Sirius Benefit Plans? ☐ Yes ☐ No
   - If yes, advise when and why coverage terminated

5. Do all full-time Employees work at least 20 hours/week for at least 10 months/year? ☐ Yes ☐ No

6. Are Contract Employees to be covered? (prior approval required) ☐ Yes ☐ No
   - If yes, provide names

7. Will the Employees pay 100% of Disability Insurance ☐ Yes ☐ No

8. Does the owner of the firm engage in any other occupation or business? ☐ Yes ☐ No
   - If yes, describe the type of business and weekly hours devoted to this business

9. Are all eligible members covered by WCB, WSIB, or CSST? ☐ Yes ☐ No
   - If no, provide explanation and details

10. Are all eligible members covered by EI? ☐ Yes ☐ No
    - If no, provide explanation and details

11. Are there any eligible employees not at work or working reduced hours due to illness or injury as of the date of this application? Is anyone away due to an automobile accident or Worker Compensation claim? ☐ Yes ☐ No
    - If yes, provide the name of the employee, reason for absence and expected date of return

12. Will coverage for Health and Dental benefits be extended for disabled employees? ☐ Yes ☐ No
    - If yes, confirm timeframe (24 month maximum) _____

13. **One/Two Person Firms Only**
    What is your actual monthly income, as reported on your personal income tax return, after business expenses? Disability is based on T-1 General and will be calculated on actual income. $ _____ / month

G. Coverage Requested

Class _____

Benefit	**Option ID** (locate on transmittal/proposal and enter here)	**Maximum/Cap**
Life Insurance/AD&D		
Dependent Life		N/A
Critical Illness - member	☐ Yes ☐ No	
Critical Illness - spouse	☐ Yes ☐ No	
Weekly Income		
Long Term Disability*		
Extended Health Care		N/A
Dental		N/A

Business Overhead Expense**	☐ Yes ☐ No	Amount

* Does the Owner wish to 'opt out' of LTD? ☐ Yes ☐ No

**Only firms of 1-4 lives are eligible for this coverage

Class _____

Benefit	**Option ID** (locate on transmittal/proposal and enter here)	**Maximum/Cap**
Life Insurance/AD&D		
Dependent Life		N/A
Critical Illness - member	☐ Yes ☐ No	
Critical Illness - spouse	☐ Yes ☐ No	
Weekly Income		
Long Term Disability		
Extended Health Care		N/A
Dental		N/A

Declaration of Policyholder

We hereby request that all eligible members are insured under this group. We understand and agree that the effective date of this coverage shall be the latest of:

a) the date requested on this application;
b) the first of the month following the date this application is signed;
c) the first of the month following the date on which the minimum enrolment requirements are met
d) the date on which all information is compiled and sold in accordance with Sirius Benefit Plan guidelines.

We confirm that the information provided in this application is true and accurate and agree that any false information or declaration on our part constitutes grounds for revoking the coverage. We agree to provide all necessary information for the sound administration of the policy and to ensure the submission of all data to Sirius Benefit Plans, in a timely manner.

We hereby authorize Sirius Benefit Plans to arrange automatic deductions from our bank account on the 1st of the month, if we have chosen this option under the Premium Payment and Billing section of this application. This authorization may be cancelled at any time by written request.

We are providing a deposit cheque in the amount of $ _____ (approximately one month's premium) to bind the coverage. We recognize that if we decide not to proceed with this program we will forfeit the deposit as it will be retained in order to offset expenses incurred by Sirius Benefit Plans.

Subject to the above, it is understood and agreed that the following rules apply:

1. If the group is a 1-2 person group, the initial coverage for each member is only effective on the first of the month following the underwriting/approval of all members of that group;
2. An employee who is not actively at work on a full-time full-pay basis on the effective date of the group will only become eligible to apply for coverage upon returning to full-time, full-pay basis (all eligibility requirements, including evidence of insurability, are applicable);
3. A dependent who is confined to a hospital on the effective date of the group will be eligible to apply for coverage upon discharge from the hospital (all eligibility requirements, including evidence of insurability, are applicable).
4. A full-time employee is an employee who works a minimum of 20 hours per week.
5. **Coverage is mandatory:**
    - **i. for all full-time employees enrolled on a existing plan, if this plan is replacing an existing plan;**
    - **ii. if no existing plan, the plan must have the following minimum participation overall in order to be approved for this program;**
        - **100% from 1-9 LIves**
        - **85% from 10-24 Lives**
    - **iii. for all new full-time employees hired after the effective date of this plan.**
6. If a Pre-Authorized Payment is returned from your bank, you will have 31 days to rectify the situation and to pay all outstanding premiums. If premium is not paid within 31 days your account will be deemed as overdue and will be subject to termination.
7. 30 day notice is required to cancel this program, once it is in effect.

Signed at _____ on _____

City, Province

Policyholder Representative _____ Title _____

Signature _____

Agent Name _____ Signature _____

Benefits Underwritten or provided by:
SSQ Financial Group
Worldcare
Solareh

Benefits Administered by:
Sirius Benefit Plans