APPLICATION FOR ACCIDENT AND SERIOUS ILLNESS DISABILITY INSURANCE

CAMDEN UNDERWRITING AGENCIES INC.

If more space is required to complete a section, please include details in section 4.2.

1. Policyowner/Group Information

1.1 Policyowner/Applicant

Registered legal name:

What name should appear on your Employee Booklets and Benefit Cards? ◯ Name above ◯ Other:

Address (number, street)	City	Province	Postal code

1.2 Plan Administrator

Plan Administrator #1 (name)	Telephone	Email address
Plan Administrator #2 (name)	Telephone	Email address

1.3 Type of Business (goods or services provided)

1.4 Ownership

Select one: ◯ Sole Proprietorship ◯ Partnership ◯ Corporation ◯ Limited Liability Partnership

Name(s) of Owner(s), if Sole Proprietorship, Partnership or Limited Liability Partnership

1.5 Affiliated Companies – to be included? ◯ **Yes** ◯ **No**

If more than 1 affiliated company, complete and **attach a list** of affiliated companies.
Is billing sub-totalling required? ◯ Yes ◯ No

Division	Legal Name	Name to appear on booklet and benefit cards

Address (number, street)	City	Province	Postal code

Plan Administrator (name)	Telephone	Email address

Business relationship to Policyowner: ◯ Common Ownership ◯ Subsidiary ◯ Other:

Nature of Business	Number of Employees in affiliated company

1.6 REQUESTED EFFECTIVE DATE for all coverage is 12:01 a.m. **EST** on:

(day), (month), (year).

FIRST YEAR RENEWAL DURATION:

15 months

Reset Form

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2. Employee Information

2.1 Divisions and Class Descriptions

Division #	Class	Class Description

If additional Divisions/Classes are required, complete, sign and attach separate listing titled "Division and Class Structure Appendix"

2.2 Definition of Salary (check all that apply)

◯ Base Salary ◯ Commissions* ◯ Bonus**

◯ Dividends included in Owners and /or Executives definition of earnings (3 year average). Separate class required.

*Dividends paid through a holding company are not eligible under the definition of salary.

If commissions/bonuses are to be included, salary to be based on:

◯ Previous calendar year T-4 or ◯ the average of the previous 2 years T-4's

** If bonus to be included – advise: Frequency of Bonus: ◯ Annual ◯ Monthly ◯ Other:

Explain how Bonus is determined or calculated:

2.3 Total Number of Employees

As of policy effective date, total number of employees to be insured _____ Total of payroll _____

a) Employees must be actively at work a minimum of **20 hours per week,** reside in Canada, with provincial health coverage, and be employed on a permanent basis in Canada, or indicate the minimum hours per week, if different from above: _____ hours

Are there any employees excluded from coverage? ◯ Yes ◯ No – Explain why:

2.4 Participation Requirements

Participation under this Plan is ◯ Mandatory* ◯ Non-mandatory**

* If participation is Mandatory, 100% of all eligible employees who are actively at work must be insured for all benefits for which they are eligible. If the Plan is 100% Employer paid, it is a Mandatory Plan.

**If participation is Non-mandatory, an eligible employee is allowed to refuse all coverage, subject to the minimum participation requirements of the Policy. An employee refusing coverage under the Plan must refuse all coverage. Refusal of some, but not all, coverage is not permitted.

2.5 Policyowner Premium Contributions

Division: _____ _____ _____

Class: _____ _____ _____

Indicate the percentage of the cost to be paid by **the Policyowner**.

Accident & Serious Illness Disability*	_____ _____ _____

Note that if the Accident and Serious Illness Disability of 67% of Earnings or greater is desired, the plan must be taxable. The taxable/non/taxable status of disability benefits may vary by employee class.

2. Employee Information (cont'd)

2.6 Waiting Period

Division: _____ _____ _____

Class: _____ _____ _____

3 or 6 Months or **other** (please specify) of continuous employment: _____ _____ _____

Waiting Period to Apply to: ◯ Employees currently within a waiting period and Future Employees ◯ Future Employees Only

2.7 Workplace Safety Legislation

Are all employees covered by provincial workplace safety legislation (e.g. WSIB, WCB/CSST. WorkSafe (B.C.)

◯ Yes ◯ No– If "No", Industry exempt? ◯ Yes ◯ No

◯ Yes ◯ No– If "No", indicate those employees who are not covered: ______________________________

2.8 Are Benefits Union negotiated? ◯ **Yes** ◯ **No**

If yes, Include a complete copy of the Union Collective Agreement and answer questions below.

(i) Are all Classes **Union** negotiated? ◯ Yes ◯ No**

** If **No**, indicate which Classes are **Union** negotiated:

(ii) Date of last **Union** negotiation: ____________________

2.9 Employee Classification

Are any proposed employees/insured employed on a contract or consultant basis, as members of the Board of Directors, Shareholders, or Sub-Contractors of the Policyowner? ◯ Yes ◯ No (If "Yes", indicate those employees/insureds below.

Note: additional details may be required to determine eligibility under the terms of the Policy.

Name (last, first)	Work primarily for Policyowner?	How compensated? T-4/RL-1	How compensated? Fee for Service
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

2.10 Employees Not Actively at Work ◯ **Yes** ◯ **No**

List ALL individuals who are currently absent from work due to the following: (not including vacation)

Reason Code:

(i) Maternity/Paternity Leave
(ii) Layoff
(iii) Leave of Absence
(iv) Workplace safety benefits (e.g. WSIB/WCB/CSST)
(v) Short (WI) or Long Term Disability (LTD) with another carrier
(vi) Employment Insurance Sickness Benefits (EI)
(vii) Reduced hours/modified duties/gradual return to work program
(viii) Other (please explain):

Name (last/first)	Date of birth (dd/mm/yyyy)	Reason code for absence	Date of leave or disability	Expected return to work	Claim Type (For employees listed with Reason code (iv) or (viii) inclusive, provide details of claim below)	Applied for	Approved
					◯ Workplace safety benefits ◯ WI ◯ EI ◯ LTD ◯ Life Waiver of Premium	◯ Yes ◯ No	◯ Yes ◯ No
					◯ Workplace safety benefits ◯ WI ◯ EI ◯ LTD ◯ Life Waiver of Premium	◯ Yes ◯ No	◯ Yes ◯ No
					◯ Workplace safety benefits ◯ WI ◯ EI ◯ LTD ◯ Life Waiver of Premium	◯ Yes ◯ No	◯ Yes ◯ No
					◯ Workplace safety benefits ◯ WI ◯ EI ◯ LTD ◯ Life Waiver of Premium	◯ Yes ◯ No	◯ Yes ◯ No
					◯ Workplace safety benefits ◯ WI ◯ EI ◯ LTD ◯ Life Waiver of Premium	◯ Yes ◯ No	◯ Yes ◯ No

3. Unit Premium Rates

The actual premium rates at inception of the Plan will be determined in accordance with the employee data as at the Effective Date of the Policy. Note: Place "all" in the class row if Rates are the same for all classes.

	Division:	_____ _____ _____
Fully Insured Rates	**Class:**	_____ _____ _____
Accident & Serious Illness Disability (per $100 of insurance)		_____ _____ _____

4. Schedule of Benefits

4.1 ACCIDENT & SERIOUS ILLNESS DISABILITY

a) Division/Class	_____/ _____	_____/ _____	_____/ _____
b) Percentage of Monthly Earnings*, or	_____%	_____%	_____%
c) Graded Scale (if differs by class, indicate in section 4.2)	◯ 66.67% of the first $2,250, 50% of the next $3,500, 44% of the balance (default), or ◯ _____% of the first $_____, _____% of the next $_____, and _____% of the first excess		
d) Maximum Monthly Benefit	$_____	$_____	$_____
e) Elimination Period (days)	_____ Injury _____ Sickness	_____ Injury _____ Sickness	_____ Injury _____ Sickness
f) Maximum Benefit Period	◯ 2 year ◯ 5 year ◯ 65 less elimination period	◯ 2 year ◯ 5 year ◯ 65 less elimination period	◯ 2 year ◯ 5 year ◯ 65 less elimination period
g) Own Occupation Period (years)	_____	_____	_____
h) Survivor Benefits	◯ None ◯ 3 months ◯ 6 months	◯ None ◯ 3 months ◯ 6 months	◯ None ◯ 3 months ◯ 6 months
i) Cost of Living Allowance (COLA)	◯ No, **OR** _____%	◯ No, **OR** _____%	◯ No, or _____%
Termination Age	65		

*If percentage of Monthly earnings note in b) above is 67% or greater, and/or the Employer pays any portion of the Accident and Serious Illness Disability premium, then the benefit will be issued as a taxable benefit. Can vary by class.

CPP/QPP integration will be primary. The all source maximum benefit is 85% of pre-disability take home pay when benefits are non-taxable, or 85% or the pre-disability Monthly Earnings when the benefits are taxable.

4.2 Corrections / Amendments / Clarifications (for Applicant use)

5. Applicant Declarations, Authorizations and Signatures (Signatures must be originals)

The Applicant hereby declares that:

(1) the statements and answers above shall constitute the Application for and form part of the Contract. As such, errors or misrepresentation of information may invalidate coverage, and the Applicant certifies that the answers given and the information in this Application and in other documents supporting this Application for benefits are true, full, and complete;

(2) in the event the Applicant forms part of a Limited Liability Partnership, all parties belonging to the Limited Liability Partnership consent and authorize the Applicant to enter into and bind the Limited Liability Partnership in respect to this Contract;

(3) the insurance will become effective in accordance with and subject to the terms and conditions of the Policy to be issued to the Applicant but in no case shall it become effective until this Application has been approved by The Empire Life Insurance Company (Empire Life);

(4) the Applicant has obtained individual plan member consent to the collection, use and disclosure of plan member personal information required for plan enrolment and ongoing administration of the plan;

(5) the Applicant confirms the appointment of the Advisor(s) identified in Section 6 of this Application to act as the Consultant/Agent of Record for this policy. It authorizes said Consultant/Agent of Record to:

(a) receive any information that may be requested regarding existing plans, future plans, or quotations on the insurance plan from any insurance company or other organizations administering such plans. Information released will not include plan member's detailed claims information; and

(b) receive any commissions in respect to any existing or future contracts pertaining to the Employee Benefits Plan.

This appointment will remain in effect until revoked by the Applicant in writing.

On behalf Camden Underwriting Agencies Inc. we acknowledge and understand that Accident and Serious Illness Disability benefits plan being purchased and administered is not a full standard Group Long Term Disability benefits plan.

We acknowledge that under the Accident and Serious Illness Disability plan, our employees will only be eligible for benefits in the event they become disabled as a result of a limited list of "Covered Conditions" as defined in the group policy. We also acknowledge that the purpose of the plan is not to provide coverage for disabilities generally and there is no coverage in the event disability results from any illness or condition that is not a "Covered Condition". The premiums in respect of the group policy have been set in accordance with this restricted coverage.

As the plan sponsor, we acknowledge that we are responsible for ensuring that our plan members understand the limited coverage of the Accident and Serious Illness Disability benefits plan.

We also acknowledge that the coverage restrictions and exclusions of this new plan have been explained to us and we understand them.

In the case of errors or omissions discovered by Empire Life in the Application, Empire Life is hereby authorized to amend the Application by noting the change in section 4.5 entitled "Corrections/Amendments/Clarifications". Acceptance by the Applicant of the Policy accompanied by a copy of this Application so amended, shall constitute ratification of such "Corrections/Amendments/Clarifications".

Completed and signed at _____ this _____ day of _____.
(city and province) (month) (year)

for _____
Applicant – full company legal name (PLEASE PRINT)

by X _____
Signature of authorized company official PRINT name/title in FULL

by X _____
Signature of witness PRINT name/title in FULL

6. Advisor Information

Advisor's Commitment:

To the best of my/our knowledge and belief all statements in this Application are true and complete.

I/we have read and understand the form.

I have advised the Applicant not to terminate any existing coverage until notice has been received that the coverage being applied for is accepted.

I have provided to the Applicant a statement of disclosure outlining the fact that I may receive compensation in the form of commissions, bonuses, conference programs or other incentives, and any conflicts, or potential conflicts of interest.

I am not aware of any additional information material to the underwriting and acceptance of this Application for Group Insurance.

	Use this column if there are two Advisors
Date	Date
Company Name	Company Name
Address – Street/Suite	Address – Street/Suite
City Province Postal Code	City Province Postal Code
Telephone Fax	Telephone Fax
Email Address	Email Address
Group Office	Group Office
Percentage of Case	Percentage of Case
Name of Advisor – Print name in full	Name of Second Advisor – Print name in full
Signature of Advisor X	**Signature of Second Advisor** X

PLEASE ENSURE THAT:

1) All required sections of the Application have been completed and it has been signed and dated prior to the requested effective date.

2) Enrolment Forms and, where necessary, Group Non-Medical Declarations have been filled out and enclosed for all employees and that additional evidence requirements have been communicated to employees.