The *Builders* Benefits Plan

Group Benefits Application

For internal use only

Contract # ____________

Applicant Information

Legal Company Name ____________________

Effective Date Requested

(Month) ________ (Day) __01__ (Year) _______

Operating As: ____________________ Address: ____________________

City: ____________________ Province: ____________________ Postal Code: ______________

Administrator Name: ____________________ Title: ____________________

Phone: ____________________ Email: ____________________

Executive Contact (if different): ____________________ Title: ____________________

Phone: ____________________ Email: ____________________

Applicant's Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) such statements and answers will form part of the group contract or policy issued by The Benefits Trust and/or its insurance partners; (2) the benefits coverage under the group contract or policy shall become effective in accordance with and subject to the terms of the group contract or policy issued to the applicant; (3) in no case shall coverage become effective until the later of the payment of the initial deposit and approval of this application by The Benefits Trust; and (4) The Benefits Trust will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved. The attached Schedule of Benefits forms part of the application.

The initial deposit of $ ____________________ is included with this application. Negotiation of the deposit will not, of itself, constitute approval of the application. The deposit will be applied against the first month's contribution statement from The Benefits Trust.

Dated at ____________________ this ______________ day of ____________________, ______________

by ____________________ ____________________

(Applicant's signature) (Title)

____

(Applicant's printed name)

Broker / Agent Information and Declaration

Send Certificate Card to ˜ Client ˜ Broker

Broker / Agent Name: ____________________ Title: ____________________

Broker / Agent Corporate Name: ____________________

Address: ____________________

City: ____________________ Province: ____________________ Postal Code: ______________

Phone: ____________________ Fax: ____________________ Email: ____________________

I have advised the applicant: (1) not to terminate any existing coverage until notice has been received in writing that the coverage being applied for is accepted; and (2) no coverage is in existence until this application is approved by The Benefits Trust.

By: ____________________ Date: ____________________

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Agent Number: ______________

Commission Scale: ______________

Plan Guidelines

- Minimum 3 Employees including you, the business owner.
- Eligible Employees must work a minimum of 24 hours per week.
- Waiting period for Full Time Employees is three (3) months unless waived in full by the Employer upon enrollment. The waiting period does not apply to Eligible Employees currently on payroll as of effective date of benefits plan.
- Coverage ceases at age 70.
- Health Care Spending Account contributions must be fully employer-funded in accordance with Revenue Canada guidelines.
- Plan will renew annually on your policy anniversary date.

Schedule of Benefits

Class	Class Description
____________	____

Mandatory Benefits

- Accident Income Replacement
- Accidental Death & Dismemberment

Benefit terminates at age 70.

Optional Benefits

Extended Health Care ˜ Yes ˜ No
Benefit terminates at employee age 70.

Dental Care ˜ Yes ˜ No
Benefit terminates at age 70.

Critical Illness ($25,000) ˜ Yes ˜ No
Benefit terminates at age 65.

Life Insurance ($25,000) ˜ Yes ˜ No
Life Insurance reduces by 50% at age 65. Benefit terminates at age 70.

Virtual Health Care & Employee Assistance Program ˜ Yes ˜ No
Benefit terminates at employee age 70.

Health Care Spending Account ˜ Yes ˜ No

Benefit Amount: _______________

- Adjudicated as a Balance Carry Forward plan. Any unused HCSA balance from one year may be carried forward to the next year. Any balance carried forward that has not been spent by the end of the next year will revert to the company.
- Benefit will be pro-rated for new employees upon eligibility, based on the number of full months worked in the benefit year.
- Changes in benefit amount due to seniority take effect at the start of the next benefit year, and will not be pro-rated over the year.
- Benefit terminates at age 70.
- Option to add just a HCSA for part-time employees

Other Notes:

Schedule of Benefits

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Other Notes:

PAYOR'S AUTHORIZATION FOR PRE-AUTHORIZED DEBITS FOR BUSINESS PURPOSES

1. Payor's Name and Address – please print

   We warrant and represent that the following information is accurate.

Company Name		
Street		
Town	Postal Code	Telephone No.

Name of Payor's Financial Institution (the "Processing Institution")			
Street		Town	
Postal Code	Bank No.	Transit No.	Account No.

   We have attached a specimen cheque marked "VOID" to this payor authorization (the "Authorization").

   We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD.

2. Payee's Name and Address – please print

Name of Payee (the "Payee") The Benefits Trust		
Street: 3800 Steeles Avenue West, Suite #102W		
Town: Vaughan, Ontario	Postal Code: L4L 4G9	Tel: (905) 264-8990

3. We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization and that all persons signing this Authorization are our authorized signing officers and are empowered to enter into this agreement.

5. We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:
   - payment of group employee benefit plan.

6. We may cancel the Authorization at any time upon providing written notice to the Payee.

7. We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by us.

8. Unless otherwise agreed to in writing, the Payee will provide to us, at the address provided in Section 1:

   a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the first PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);

   b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of every PAD; and

   c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a PAD in full or partial payment of a billing received by us for a payment obligation that meets the requirements of Section 2 or Rule H4, no notice is required.

9. The Payee may issue a PAD monthly including deposit (unless binder cheque is included) in a dollar amount as presented to the Payor and may vary with usage and taxes.

10. We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. We may dispute a PAD only under the following conditions:
    (i) the PAD was not drawn in accordance with the Authorization;
    (ii) the Authorization was revoked; or
    (iii) pre-notification, as required under Section 8 was not received.

    We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 10 business days after the date on which the PAD in dispute was posted to the Account.

    We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between us and the Payee, outside the payment system.

13. We agree that the information contained in the Authorization may be disclosed to the Payee's Financial Institution as required to complete any PAD transaction.

14. We understand and accept the terms of participating in this PAD plan.

____
(COMPANY NAME)

____
(AUTHORIZED SIGNATURE)

____
(AUTHORIZED SIGNATURE)