

Application For Group Insurance A **WestGUARD**

(for firms with 3-4 employees)

Firm Information

Firm Name		Street Address:		
		Mailing Address:		
		<input type="checkbox"/> same as above		
City	Province	Postal Code	Telephone Number ()	Fax Number ()
E-Mail Address	Contact Name	Contact Title	Association	
Description of Operation(s)		Type of Organization <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Other	If "Other" please specify	
Date Operations/Business Commenced (yy/mm/dd)		Proposed Effective Date (yy/mm/dd)		
Is There Group Insurance Currently in Effect? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Carrier	Date of Termination (yy/mm/dd)		

Firms with fewer than 5 employees must submit evidence of insurability for all employees and their eligible dependents.

Eligible Employees are:

- Full time employees (working at least 20 hours per week for at least nine months out of the year) employed on a permanent basis on or prior to the effective date of the policy;
- Full time employees (working at least 20 hours per week for at least nine months out of the year) employed on a permanent basis after the effective date of the policy who have three months continuous full time employment.

Number of Eligible Employees	Number of Employees Enrolling	Number of Employees With Dependents
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100% participation is required for firms with fewer than 5 eligible employees.

ALL ELIGIBLE MEMBERS NOT ENROLLING MUST COMPLETE A WAIVER OF ALL COVERAGE FORM.

You will receive your monthly billing statement by e-mail. Please provide up to three e-mail addresses:

E-mail #1	E-mail #2	E-mail #3
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Waiting Period: 3 Months 6 Months 9 Months 12 Months

Are Any Employees Currently Disabled?
 Yes No

If "Yes", please complete

Employee Name	Date of Disability	Date of Expected Return To Work	Type of Benefits Being Collected

Please also provide information regarding waiver of previous carrier for disabled lives, if applicable.

Please Note: Employees not actively at work on the effective date of the firm's coverage will become insured on the date they return to active work, subject to the terms of the Group Policy.

Online Administration Access to administration functions, downloadable claim forms, employee certificates and more.

Plan Administrator Name	Plan Administrator E-mail Address*
Plan Administrator Name	Plan Administrator E-mail Address*
Plan Administrator Name	Plan Administrator E-mail Address*

*E-mail address must be unique for each plan administrator.

Benefit Selection To be elected at firm level (all employees must apply)

Class Description

Basic Life and Accidental Death and Dismemberment MANDATORY FOR ALL

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C
<input type="checkbox"/> \$ _____ Flat or	<input type="checkbox"/> \$ _____ Flat or	<input type="checkbox"/> \$ _____ Flat or	<input type="checkbox"/> \$ _____ Flat or
<input type="checkbox"/> _____ % of Annual Earnings	<input type="checkbox"/> _____ % of Annual Earnings	<input type="checkbox"/> _____ % of Annual Earnings	<input type="checkbox"/> _____ % of Annual Earnings
Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____

Dependent Life

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C
\$ _____ Spouse \$ _____ Child	\$ _____ Spouse \$ _____ Child	\$ _____ Spouse \$ _____ Child	\$ _____ Spouse \$ _____ Child

Weekly Income

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C
<input type="checkbox"/> _____ % of Weekly Earnings _____	<input type="checkbox"/> _____ % of Weekly Earnings _____	<input type="checkbox"/> _____ % of Weekly Earnings _____	<input type="checkbox"/> _____ % of Weekly Earnings _____
or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____
Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____
<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable
Waiting Period (Accident): _____ Days	Waiting Period (Accident): _____ Days	Waiting Period (Accident): _____ Days	Waiting Period (Accident): _____ Days
Waiting Period (Sickness): _____ Days	Waiting Period (Sickness): _____ Days	Waiting Period (Sickness): _____ Days	Waiting Period (Sickness): _____ Days
Benefit Period: _____	Benefit Period: _____	Benefit Period: _____	Benefit Period: _____

Note: If any portion of the Weekly Income is paid by the EMPLOYER, the benefit is considered a TAXABLE benefit at the time of claim.

Long Term Disability

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C
<input type="checkbox"/> _____ % of Monthly Earnings _____	<input type="checkbox"/> _____ % of Monthly Earnings _____	<input type="checkbox"/> _____ % of Monthly Earnings _____	<input type="checkbox"/> _____ % of Monthly Earnings _____
or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____	or <input type="checkbox"/> Graded Schedule _____
Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____	Max: \$ _____ NEL: \$ _____
<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable	<input type="checkbox"/> Taxable <input type="checkbox"/> Non - Taxable
Waiting Period: _____ Days	Waiting Period: _____ Days	Waiting Period: _____ Days	Waiting Period: _____ Days
Benefit Period: _____	Benefit Period: _____	Benefit Period: _____	Benefit Period: _____

Note: If any portion of the Long Term Disability is paid by the EMPLOYER, the benefit is considered a TAXABLE benefit at the time of claim.

Extended Health Care

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C

Vision (This coverage must be retained for a minimum of 24 months)

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C

Note: The vision benefit is not available to employees who are waiving the Extended Health Care coverage.

Dental

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C

Other/Notes

ALL EMPLOYEES	CLASS A	CLASS B	CLASS C

Bank or Financial Institution Information

In order to bind coverage this section **must** be completed and all required payment information is to be enclosed.

Name of Bank or Financial Institution

Branch Address

City

Province

Postal Code

- Your treatment of each cheque or debit shall be the same as if I/we had personally issued a cheque.
- Delivery of this authorization to you constitutes delivery by me/us.
- This authorization can be cancelled by me/us at any time upon written notice.
- I/We will ensure that funds are available to cover the amount of withdrawal, as notified to me/us by Western Financial Group Insurance Solutions.
- \$10.00 service fee will be charged to each (P.A.C.) returned for non-sufficient funds (NSF).

Please attach a void cheque and complete the following information which is found on the bottom of your cheque as per the sample below. This information is required to ensure funds are withdrawn from the correct account.

(1) Transit Number (5 Digits)

(2) Bank Number (3 Digits)

(3) Account Number (Various)

Sample

Name	_____	20	_____
Address	_____		
Pay to	_____		\$ _____
	_____		/100 Dollars
Bank/Credit Union	_____		
(1)	(2)	(3)	
09267:	002:	638:194:02	
(Transit)	(Bank)	(Account Number)	_____

Binding Coverage

Enclosed binder cheque amount \$ _____.

*** Binder cheque and PAC information must be enclosed to avoid any delays in claims processing.**

Certification and Authorization

All Statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete.

At Western Financial Group Insurance Solutions, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a group life and health benefits file. Access to your information will be limited to:

- our employees and representatives in the performance of their jobs;
- persons to whom you have granted access in writing; and
- persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

Western Financial Group Insurance Solutions is focused on respecting your privacy and maintaining confidentiality of information. We have safeguards in place to protect your personal, business, and financial information which adheres to the Ten Privacy Principles as covered by the Personal Information Protection and Electronic Document Act (www.privcom.gc.ca). To learn more about Western Financial Group Insurance Solutions' commitment to privacy and security refer to our website: www.westernfgis.ca

Sales Representative

Date (yy/mm/dd)

Signature and Title of Authorized Official

Date (yy/mm/dd)



Complete and send to:

WestGUARD, Western Financial Group Insurance Solutions
201-600 Empress Street, Winnipeg, Manitoba R3G 0R5
Toll Free: 1-800-665-8990

Western Financial Group (Network) Inc.
10000-WGE/09-2012