Application For Group Insurance B

(for firms with 5+ employees)

WestGUARD

Firm Information

Firm Name	Street Address		
	Mailing Address: ❑ same as above		
City	Province	Postal Code	Telephone Number ( )	Fax Number ( )
Email Address	Contact Name	Contact Title	Association
Description of Operation(s)	Type of Organization ❑ Sole Proprietorship ❑ Partnership ❑ 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? ❑ Yes ❑ 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

If the number of employees enrolling is less than the number of eligible employees, please list the names of the eligible employees NOT enrolling:

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

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

Email #1	Email #2	Email #3

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)

Basic Life and Accidental Death and Dismemberment MANDATORY FOR ALL

❑ $_____ Flat or ❑ _____% of Annual Earnings

Max: $_____ NEL: $_____

Dependent Life

$ _____ Spouse

$ _____ Child

Weekly Income

❑ _____ % of Weekly Earnings _____ or ❑ Graded Schedule_____

_____ _____

Waiting Period (Accident): _____ Days Waiting Period (Sickness): _____ Days Benefit Period: _____

Max: $_____ NEL: $_____

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

Long Term Disability

❑ _____ % of Monthly Earnings _____ or ❑ Graded Schedule_____

_____ _____

Max: $ _____ NEL: $_____ Benefit Period: _____

❑ Taxable ❑ Non - Taxable Waiting Period :_____ Days

Note: If any portion of the premium 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

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

Note: The vision benefit will not be available to employees who are waiving the Extended Health Care Coverage.

Dental

Health Spending Account

Dollar Amount $ _____ / 12 month period per ❑ Certificate ❑ Insured Employee and Each Dependent

Other/Notes

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
Address

_____ 20 _____

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)

Western FINANCIAL GROUP

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.
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