Régime assuré par :

SERVICE COLLECTIF TOTAL INC.
Group Insurance Firm

3078 Dagenais Blvd W
Laval QC H7P 1T6

Tel.: (450) 625-7000 Toll free: 1(888) 625-7001
Fax: (450) 625-8333 www.sctotal.com

La Capitale
assurances et gestion du patrimoine

Reserved for use by Service Collectif Total Inc.

☐ **GROUP INSURANCE PROPOSAL**

☐ MODIFICATION TO CONTRACT NO. ________ Employer No. ________

POLICYHOLDER

Name of Policyholder:

Full address:

No. **Street** **Suite No.**

City **Province** **Postal Code**

Decision maker: **Contract administrator:**
☐ **Same as opposite** ☐ **Other, specify:**

Correspondence:

Telephone: **Fax:** ☐ **English** ☐ **French**

E-mail: **Start of operations:** |____|__|__| YYYY MM DD

List any affiliated or associated companies whose employees are insured in the same capacity as the Policyholder:

EFFECTIVE DATE

Contract version: March 2008

Effective date: |____|__|__| YYYY MM DD **at 12:01 a.m.** **Renewal date:** |____|__|__| YYYY MM DD

DEFINITION OF ELIGIBILITY

CLASS 1 ______________________

Permanent employees at work for at least _______ hours per week and having satisfied the eligibility waiting period of ________ days of active full-time work. Employees in the following classes are excluded:

____

CLASS 2 ______________________

Permanent employees at work for at least _______ hours per week and having satisfied the eligibility waiting period of ________ days of active full-time work. Employees in the following classes are excluded:

____

DEFINITION OF TOTAL DISABILITY

A state of incapacity, resulting from an illness or an accident, which, **during the Long Term Disability Insurance elimination period (if this benefit is included in the Group Insurance Proposal) and the following 24 months**, prevents the participant from carrying out each and every duty of his or her employment; and thereafter, although not necessarily requiring continuous medical care, prevents the participant from engaging in any gainful activity for which he or she is reasonably qualified by education, training or experience. Total disability is determined regardless of the existence or availability of employment.

GENERAL INFORMATION

CLASS 1

Number of participants: __________

Booklets required: English _______

French _______

Number of pay periods per calendar year
☐ 12 ☐ 24 ☐ 26 ☐ 52

Benefits included:
☑ Basic Life ☑ AD&D
☑ Dependents' Life
☐ Optional Life
☐ Critical Illness
☐ Short term ☐ Long Term
☑ Health ☐ Dental Care

Employer's financial participation in premium payments: _______% overall

OR

____

CLASS 2

Number of participants: __________

Booklets required: English _______

French _______

Number of pay periods per calendar year
☐ 12 ☐ 24 ☐ 26 ☐ 52

Benefits included:
☑ Basic Life ☑ AD&D
☑ Dependents' Life
☐ Optional Life
☐ Critical Illness
☐ Short term ☐ Long Term
☑ Health ☐ Dental Care

Employer's financial participation in premium payments: _______% overall

OR

____

Were employees covered under a previous contract? (If **yes**, please provide the following information and attach a copy of the last invoice along with a list of participants who have satisfied the deductible in whole or in part, where applicable). ☐ YES ☐ NO

Insurer: ______________________ Contract No.: ____________ Cancelled on: |____|__|__| YYYY MM DD

GENERAL INFORMATION (continued)

Question	Answer
Are there any participants who are resident outside Quebec? If **yes**, please specify:	☐ YES ☐ NO
Are any participants self-employed? If **yes**, please specify:	☐ YES ☐ NO
Are there any employees whose salary includes dividends? If **yes**, please specify:	☐ YES ☐ NO
Are there any participants who are NOT covered under applicable workers' compensation legislation (CSST, WSIB)? If **yes**, please specify:	☐ YES ☐ NO
Are there any participants who are NOT covered under the Employment Insurance Act (HRSDC)? If **yes**, please specify:	☐ YES ☐ NO
Are there any participants who are NOT currently actively at work (sick leave or absent due to disability, maternity, parental or sabbatical leave, temporary layoff…)? If **yes**, please provide details below:	☐ YES ☐ NO

Name	**Date of departure / disability**	**Nature of leave / disability**	**Scheduled return to work date**

PLAN APPLIED FOR

BASIC LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

(including Legal Access Insurance, for Quebec residents only)

CLASS 1

Coverage: ____________________

Rounded to next highest $1,000? ☐ YES ☐ NO

Maximums: Without evidence: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

With evidence: ☐ $200,000 ☐ $250,000 ☐ $300,000

Grandfather clause: If this benefit was covered under the previous contract and you wish to apply the grandfather clause, please indicate the maximums held under the previous contract and attach a copy of the invoice of the last month insured (groups with a minimum of 5 participants covered under the previous contract).

Without evidence ____________ With evidence ____________

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

CLASS 2

Coverage: ____________________

Rounded to next highest $1,000? ☐ YES ☐ NO

Maximums: Without evidence: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000

With evidence: ☐ $200,000 ☐ $250,000 ☐ $300,000

Grandfather clause: If this benefit was covered under the previous contract and you wish to apply the grandfather clause, please indicate the maximums held under the previous contract and attach a copy of the invoice of the last month insured (groups with a minimum of 5 participants covered under the previous contract).

Without evidence ____________ With evidence ____________

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

DEPENDENTS' LIFE INSURANCE

(including Legal Access Insurance, for Quebec residents only)

CLASS 1 ☐ $10,000 - Spouse, $5,000 - Child ☐ $5,000 - Spouse, $2,500 - Child

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

CLASS 2 ☐ $10,000 - Spouse, $5,000 - Child ☐ $5,000 - Spouse, $2,500 - Child

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

OPTIONAL LIFE INSURANCE

CLASS 1 ☐ YES ☐ NO

CLASS 2 ☐ YES ☐ NO

Premiums are calculated individually per participant based on age, sex and smoker status, as well as the amount of coverage selected (maximum $100,000). Please indicate the Optional Life Insurance coverage required on each participant's application.

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

PLAN APPLIED FOR (continued)

CRITICAL ILLNESS INSURANCE

CLASS 1 ☐ YES ☐ NO

Amount of insurance: Participant and spouse: $25,000
Dependent child: $5,000

Waiver of premiums in the event of total disability: None

CLASS 2 ☐ YES ☐ NO

Amount of insurance: Participant and spouse: $25,000
Dependent child: $5,000

Waiver of premiums in the event of total disability: None

SHORT TERM DISABILITY INSURANCE

CLASS 1

Elimination period: Accident / hospitalization / illness (in calendar days)

☐ 0 / 0 / 7 ☐ 0 / 14 / 14

Benefit amount: (% of weekly salary) ________% OR

________% of the first $_____________ of weekly salary

and ________% of any excess

☐ Taxable benefits ☐ Non-taxable benefits*

* **Employees must pay the entire premium for this coverage in order for benefits to be non-taxable.**

Maximums:

Without evidence: ☐ $800 ☐ Other: $________

With evidence: ☐ $800 ☐ Other: $________

Maximum duration of benefits: (splitting 1/7)

☐ 17 weeks ☐ 26 weeks

Options:

☑ Day surgery included

☐ Plan integrated with Employment Insurance (EI)

Disability benefits will be sent directly to the insured's home.

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

CLASS 2

Elimination period: Accident / hospitalization / illness (in calendar days)

☐ 0 / 0 / 7 ☐ 0 / 14 / 14

Benefit amount: (% of weekly salary) ________% OR

________% of the first $_____________ of weekly salary

and ________% of any excess

☐ Taxable benefits ☐ Non-taxable benefits*

* **Employees must pay the entire premium for this coverage in order for benefits to be non-taxable.**

Maximums:

Without evidence: ☐ $800 ☐ Other: $________

With evidence: ☐ $800 ☐ Other: $________

Maximum duration of benefits: (splitting 1/7)

☐ 17 weeks ☐ 26 weeks

Options:

☑ Day surgery included

☐ Plan integrated with Employment Insurance (EI)

Disability benefits will be sent directly to the insured's home.

Waiver of premiums in the event of total disability: After six (6) months (or after the Long Term Disability elimination period, if this coverage is included)

LONG TERM DISABILITY INSURANCE

CLASS 1

Was Long Term Disability Insurance held with the previous Insurer?

☐ YES ☐ NO ☐ N/A

Elimination period:

☐ 15 weeks ☐ 17 weeks ☐ 26 weeks

Maximum duration of benefits:

☐ 24 months ☐ Until age 65

Benefit amount: (% of monthly salary) ________% OR

________% of the first $_____________ of monthly salary and

________% of any excess

☐ Taxable benefits ☐ Non-taxable benefits*

* **Employees must pay the entire premium for this coverage in order for benefits to be non-taxable.**

Options:

☐ Cost-of-living adjustment (based on CPP or QPP) maximum 3%

Disability benefits will be sent directly to the insured's home.

CLASS 2

Was Long Term Disability Insurance held with the previous Insurer?

☐ YES ☐ NO ☐ N/A

Elimination period:

☐ 15 weeks ☐ 17 weeks ☐ 26 weeks

Maximum duration of benefits:

☐ 24 months ☐ Until age 65

Benefit amount: (% of monthly salary) ________% OR

________% of the first $_____________ of monthly salary and

________% of any excess

☐ Taxable benefits ☐ Non-taxable benefits*

* **Employees must pay the entire premium for this coverage in order for benefits to be non-taxable.**

Options:

☐ Cost-of-living adjustment (based on CPP or QPP) maximum 3%

Disability benefits will be sent directly to the insured's home.

PLAN APPLIED FOR (continued)

LONG TERM DISABILITY INSURANCE (continued)

CLASS 1

Maximums: Without evidence: ☐ $1,000 ☐ $2,000 ☐ $2,600 ☐ $3,200 ☐ $4,000
With evidence: ☐ $3,500 ☐ $5,000 ☐ $6,000

Grandfather clause: If this benefit was covered under the previous contract and you wish to apply the grandfather clause, please indicate the maximums held under the previous contract and attach a copy of the invoice of the last month insured (groups with a minimum of 5 participants covered under the previous contract).

Without evidence ____________________ With evidence ____________________

Waiver of premiums in the event of total disability: After the elimination period for this benefit

CLASS 2

Maximums: Without evidence: ☐ $1,000 ☐ $2,000 ☐ $2,600 ☐ $3,200 ☐ $4,000
With evidence: ☐ $3,500 ☐ $5,000 ☐ $6,000

Grandfather clause: If this benefit was covered under the previous contract and you wish to apply the grandfather clause, please indicate the maximums held under the previous contract and attach a copy of the invoice of the last month insured (groups with a minimum of 5 participants covered under the previous contract).

Without evidence ____________________ With evidence ____________________

Waiver of premiums in the event of total disability: After the elimination period for this benefit

HEALTH INSURANCE

CLASS 1

Expenses exempt from any deductible and reimbursed at 100%

- ✓ **Hospitalization**: Semi-private room (two beds)
- ✓ **Travel Insurance**: Maximum stay: 6 consecutive months
- ✓ **Eye examinations**: Maximum of $50 per 24 months, per insured

User charge: (applies to prescription drugs)

☐ None ☐ $2 per prescription ☐ $5 per prescription

Deductible:

Individual: ☐ None ☐ $25 ☐ $50 ☐ $100
Family: ☐ None ☐ $25 ☐ $50 ☐ $100 ☐ $200
Single-Parent: ☐ (Same as Family)
Couple: ☐ (Same as Family)

Deductible applies:

☐ to prescription drugs, health care professionals and other eligible expenses (if no user charge applies to prescription drugs)

OR

☐ to health care professionals and other eligible expenses (if a user charge applies to prescription drugs)

Coinsurance: (applies to prescription drugs, to health care professionals and other eligible expenses)

☐ 70% ☐ 75% ☐ 80% ☐ 90% ☐ 100%

- **Prescription drugs** (Standard clause)
  ______% of the first $__________ and 100% of any excess
- **Other eligible expenses**
- **Health care professionals:**

☐ Unlimited amount per treatment, up to an eligible maximum of $500 per calendar year, per insured, per professional or group of professionals (no maximum for physiotherapy)

OR

☐ Unlimited amount per treatment, up to an eligible maximum of $300 per calendar year, per insured, per professional or group of professionals (no maximum for physiotherapy)

OR

☐ Unlimited amount per treatment, up to an overall eligible maximum of $400 per calendar year, per insured, for all professionals

OR

☐ Up to an eligible maximum of $20 per treatment and an eligible maximum of $300 per calendar year, per insured, per professional or group of professionals

Electronic claims payment: ☐ Deferred ☐ Direct

CLASS 2

Expenses exempt from any deductible and reimbursed at 100%

- ✓ **Hospitalization**: Semi-private room (two beds)
- ✓ **Travel Insurance**: Maximum stay: 6 consecutive months
- ✓ **Eye examinations**: Maximum of $50 per 24 months, per insured

User charge: (applies to prescription drugs)

☐ None ☐ $2 per prescription ☐ $5 per prescription

Deductible:

Individual: ☐ None ☐ $25 ☐ $50 ☐ $100
Family: ☐ None ☐ $25 ☐ $50 ☐ $100 ☐ $200
Single-Parent: ☐ (Same as Family)
Couple: ☐ (Same as Family)

Deductible applies:

☐ to prescription drugs, health care professionals and other eligible expenses (if no user charge applies to prescription drugs)

OR

☐ to health care professionals and other eligible expenses (if a user charge applies to prescription drugs)

Coinsurance: (applies to prescription drugs, to health care professionals and other eligible expenses)

☐ 70% ☐ 75% ☐ 80% ☐ 90% ☐ 100%

- **Prescription drugs** (Standard clause)
  ______% of the first $__________ and 100% of any excess
- **Other eligible expenses**
- **Health care professionals:**

☐ Unlimited amount per treatment, up to an eligible maximum of $500 per calendar year, per insured, per professional or group of professionals (no maximum for physiotherapy)

OR

☐ Unlimited amount per treatment, up to an eligible maximum of $300 per calendar year, per insured, per professional or group of professionals (no maximum for physiotherapy)

OR

☐ Unlimited amount per treatment, up to an overall eligible maximum of $400 per calendar year, per insured, for all professionals

OR

☐ Up to an eligible maximum of $20 per treatment and an eligible maximum of $300 per calendar year, per insured, per professional or group of professionals

Electronic claims payment: ☐ Deferred ☐ Direct

PLAN APPLIED FOR (continued)

HEALTH INSURANCE (continued)

CLASS 1

Options:

☐ **Vision Care Insurance** - Maximum of $150 per 24 months, per insured (expenses exempt from any deductible and reimbursed at 100%)

☐ Drugs or substances used for the treatment of **impotence**

Waiver of premiums in the event of total disability: None

CLASS 2

Options:

☐ **Vision Care Insurance** - Maximum of $150 per 24 months, per insured (expenses exempt from any deductible and reimbursed at 100%)

☐ Drugs or substances used for the treatment of **impotence**

Waiver of premiums in the event of total disability: None

DENTAL CARE INSURANCE

CLASS 1

Deductible: (applies to Basic preventive and restorative services, and to Complex restorative services and dentures)

Individual:	☐ None ☐ $25 ☐ $50
Family:	☐ None ☐ $25 ☐ $50 ☐ $100
Single-Parent:	☐ (Same as Family)
Couple:	☐ (Same as Family)

Eligible expenses:

☐ **Basic preventive and restorative services** (includes endodontic and periodontic care)

Coinsurance: ☐ 75% ☐ 80% ☐ 90% ☐ 100%

Was Dental Care Insurance held with the previous Insurer?

☐ YES ☐ NO ☐ N/A

If the group was not insured for this benefit, for the first year of insurance, eligible maximums will be proportional to the number of months between the date that the policy comes into effect and the end of the calendar year.

Annual maximum:	**First year***	/	**Subsequent years**
☐	$500	/	$1,000
☐	$1,000	/	$2,500

* In the case of a group not insured for this benefit under a previous contract

☐ **Complex restorative services and dentures** – Coinsurance: 50%
Annual maximum: $1,000

☐ **Orthodontic services** – Coinsurance: 50%
Lifetime maximum: $1,000 per child age 18 and under

Electronic claims payment included? ☑ YES

Waiver of premiums in the event of total disability: None

CLASS 2

Deductible: (applies to Basic preventive and restorative services, and to Complex restorative services and dentures)

Individual:	☐ None ☐ $25 ☐ $50
Family:	☐ None ☐ $25 ☐ $50 ☐ $100
Single-Parent:	☐ (Same as Family)
Couple:	☐ (Same as Family)

Eligible expenses:

☐ **Basic preventive and restorative services** (includes endodontic and periodontic care)

Coinsurance: ☐ 75% ☐ 80% ☐ 90% ☐ 100%

Was Dental Care Insurance held with the previous Insurer?

☐ YES ☐ NO ☐ N/A

If the group was not insured for this benefit, for the first year of insurance, eligible maximums will be proportional to the number of months between the date that the policy comes into effect and the end of the calendar year.

Annual maximum:	**First year***	/	**Subsequent years**
☐	$500	/	$1,000
☐	$1,000	/	$2,500

* In the case of a group not insured for this benefit under a previous contract

☐ **Complex restorative services and dentures** – Coinsurance: 50%
Annual maximum: $1,000

☐ **Orthodontic services** – Coinsurance: 50%
Lifetime maximum: $1,000 per child age 18 and under

Electronic claims payment included? ☑ YES

Waiver of premiums in the event of total disability: None

ADDITIONAL INFORMATION

____

____

____

____

____

____

ADDITIONAL INFORMATION

____

____

____

____

____

____

MONTHLY RATES

CLASS 1			CLASS 2		
Participant's Basic Life Insurance (per $1,000):		$__________	Participant's Basic Life Insurance (per $1,000):		$__________
Accidental Death and Dismemberment Insurance (per $1,000):		$__________	Accidental Death and Dismemberment Insurance (per $1,000):		$__________
Dependents' Life Insurance:		$__________	Dependents' Life Insurance:		$__________
Critical Illness Insurance:	Individual	$__________	Critical Illness Insurance:	Individual	$__________
	Family	$__________		Family	$__________
	Single-Parent	$__________		Single-Parent	$__________
	Couple	$__________		Couple	$__________
Short Term Disability Insurance (per $10):		$__________	Short Term Disability Insurance (per $10):		$__________
Long Term Disability Insurance (per $100):		$__________	Long Term Disability Insurance (per $100):		$__________
Health Insurance:	Individual	$__________	Health Insurance:	Individual	$__________
	Family	$__________		Family	$__________
	Single-Parent	$__________		Single-Parent	$__________
	Couple	$__________		Couple	$__________
	Surcharge 65 years and over	$__________		Surcharge 65 years and over	$__________
Dental Care Insurance:	Individual	$__________	Dental Care Insurance:	Individual	$__________
	Family	$__________		Family	$__________
	Single-Parent	$__________		Single-Parent	$__________
	Couple	$__________		Couple	$__________

THIS PROPOSAL / MODIFICATION IS AN INTEGRAL PART OF THE INSURANCE CONTRACT ISSUED IN THE NAME OF THE POLICYHOLDER

I, the undersigned, hereby request that La Capitale Insurance and Financial Services Inc. issue a group insurance contract renewable at the end of each term, and I agree that insurance shall become effective on the date indicated on page 1 of this proposal. A cheque covering the initial monthly premium, is enclosed with this proposal.

I certify that the information contained in the request for proposal and in this proposal is true and complete and I accept that any misrepresentation may entail the cancellation of the contract. If any errors or omissions are discovered by La Capitale Insurance and Financial Services Inc. (La Capitale) or Service Collectif Total Inc. (SCT), La Capitale and SCT are authorized hereunder to modify the proposal by making the requisite corrections.

I understand that participation in all benefits is mandatory for all employees who satisfy the eligibility conditions (as defined in the contract under Section 2.2.1).

Signed at: ________________________________ Date: |______|____|____|
Town/City Province YYYY MM DD

Policyholder:______________________________ Title: ______________________
Signature

Witness: ______________________________ Name: ______________________
Signature

First month's premium, in the amount of $_____________ is attached (cheque made out to **Service Collectif Total Inc.**)

DESIGNATION OF THE ADMINISTRATOR

The Policyholder hereby designates Service Collectif Total Inc. to act on its behalf as the Administrator of said group insurance contract as of its effective date. In this capacity, the Administrator shall not act on behalf of, nor represent, La Capitale Insurance and Financial Services Inc.

The Administrator is authorized and required to fulfill the administrative duties of the contract which would otherwise be carried out by the Insurer. These duties include, but are not limited to, underwriting and determining initial and renewal rates, issuing plan documentation, implementing and maintaining the files of the Policyholder, its employees and their eligibility files, providing customer service, ensuring the monthly billing of premiums as well as ensuring the recovery, accounting and submission of premiums to La Capitale Insurance and Financial Services Inc. in accordance with the provisions of said contract.

La Capitale Insurance and Financial Services Inc. is hereby authorized and required to communicate and transact directly with the Administrator for any administrative question regarding the group insurance contract. Any communication or transaction made through the Administrator shall be considered as if it had been carried out between the Policyholder and La Capitale Insurance and Financial Services Inc. La Capitale Insurance and Financial Services Inc. shall be entitled to verify all files regarding the administration of the group insurance contract held by the Administrator and the Policyholder.

Signed at: ________________________________ Date: |______|____|____|
Town/City Province YYYY MM DD

Policyholder:______________________________ Title: ______________________
Signature

Witness: ______________________________ Name: ______________________
Signature

INFORMATION ABOUT REPRESENTATIVES

BROKER 1

Name of representative: ____________________ Proportion of commissions: ________%

Brokerage firm: ____________________

BROKER 2

Name of representative: ____________________ Proportion of commissions: ________%

Brokerage firm: ____________________

BROKER 3

Name of representative: ____________________ Proportion of commissions: ________%

Brokerage firm: ____________________

DOCUMENTS TO BE ATTACHED TO THIS PROPOSAL

- Employees' duly completed, signed and dated application forms
- Declarations of insurability, duly completed, signed and dated by the relevant employees (if necessary)
- Copy of invoice from last month insured with previous insurer (if applicable)
- Cheque to cover the first month's insurance premium (made out to Service Collectif Total Inc.)

Proposition 2010-01 A