



GROUP INSURANCE PROPOSAL

MODIFICATION TO CONTRACT NO. **Employer No.**

Reserved for use by Service Collectif Total Inc.

POLICYHOLDER

Name of Policyholder: _____

Full address:
No. _____ Street _____ Suite No. _____

City _____ Province _____ Postal Code _____

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

Telephone: _____ **Fax:** _____ **Correspondence:** 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: _____/_____/_____ at 12:01 a.m. **Renewal date:** _____/_____/_____
YYYY MM DD 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: _____ **Benefits included:**
 Basic Life AD&D
Booklets required: English _____ Dependents' Life
French _____ Optional Life
 Critical Illness
Number of pay periods per calendar year Short term Long Term
 12 24 26 52 Health Dental Care
Employer's financial participation in premium payments: _____% overall
OR _____

CLASS 2
Number of participants: _____ **Benefits included:**
 Basic Life AD&D
Booklets required: English _____ Dependents' Life
French _____ Optional Life
 Critical Illness
Number of pay periods per calendar year Short term Long Term
 12 24 26 52 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)

Are there any participants who are resident outside Quebec? If yes , please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are any participants self-employed? If yes , please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are there any employees whose salary includes dividends? If yes , please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are there any participants who are NOT covered under applicable workers' compensation legislation (CSST, WSIB)? If yes , please specify:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are there any participants who are NOT covered under the Employment Insurance Act (HRSDC)? If yes , please specify:	<input type="checkbox"/> YES <input type="checkbox"/> 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:	<input type="checkbox"/> YES <input type="checkbox"/> NO

<u>Name</u>	<u>Date of departure / disability</u>	<u>Nature of leave / disability</u>	<u>Scheduled return to work date</u>

PLAN APPLIED FOR

BASIC LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

(including Legal Access Insurance, for Quebec residents only)

CLASS 1	CLASS 2
Coverage: _____ Rounded to next highest \$1,000? <input type="checkbox"/> YES <input type="checkbox"/> NO	Coverage: _____ Rounded to next highest \$1,000? <input type="checkbox"/> YES <input type="checkbox"/> NO
Maximums: <u>Without evidence</u> <u>With evidence</u> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$300,000	Maximums: <u>Without evidence</u> <u>With evidence</u> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$300,000
<u>Grandfather clause:</u> 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). <u>Without evidence</u> <u>With evidence</u> _____	<u>Grandfather clause:</u> 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). <u>Without evidence</u> <u>With evidence</u> _____
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)	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	CLASS 2
<input type="checkbox"/> \$10,000 - Spouse \$5,000 - Child	<input type="checkbox"/> \$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)	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	CLASS 2
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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)

LONG TERM DISABILITY INSURANCE (continued)

CLASS 1

- Maximums:** Without evidence With evidence
- \$1,000 \$3,500
- \$2,000 \$5,000
- \$2,600 \$3,200 \$4,000 \$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 With evidence
- \$1,000 \$3,500
- \$2,000 \$5,000
- \$2,600 \$3,200 \$4,000 \$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
	<input type="checkbox"/> \$500	/	\$1,000
	<input type="checkbox"/> \$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
	<input type="checkbox"/> \$500	/	\$1,000
	<input type="checkbox"/> \$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.)