

CAUS Canadian Benefits

Value - Value Plus - Business Value Plan

New Individual Enrollment Reinstatement

Policy # _____ Class _____ Cert.# _____
TPA Office Use Only

Individual or Employee Name:	Organization Name:	BROKER ID W _____
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APPLICANT DETAILS

Applicant Last Name: _____ First Name _____ Middle Initials: _____

Mailing Address: _____
Apt./Unit # Street Address City Province Postal Code

Home Phone: () _____ Work Phone: () _____ Email Address: _____

Date of Birth: (Day/Month/Year)	Occupation/Job Description:	Start Date is the 1st of the month after the application has been accepted: _____ <small>(Day/Month/Year)</small>
<input type="checkbox"/> Working <input type="checkbox"/> Retired <input type="checkbox"/> Other Income: \$ _____ per _____ <small>(Either: Hourly rate or Month or Year)</small>	Coverage Applying for: <input type="checkbox"/> Value (Guaranteed Issue) <input type="checkbox"/> Value Plus (Medically Underwritten) <input type="checkbox"/> Business Value Plan (Medically Underwritten)	
S.I.N. Number	Do you Smoke: <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male

COVERAGE INFORMATION

Requested Coverage:

Single Coverage (Applicant Only) Couple (Applicant and Spouse or Applicant and one Dependent) Family Coverage (Applicant, Spouse, and Dependents)

If applying for Couple or Family coverage:

Does spouse have own coverage? Yes No If yes, please complete below.

Are you and your dependent children covered under your spouse's insurance? Yes No

Spouse's Employer	Spouse's Insurance Company	Policy Number	Spouse's I.D. Number
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PREVIOUS INSURANCE CARRIER (If applicable)

For Value Plus and Business Plan applicants: if you are converting from a previous group plan within 60 days of its termination, pre-existing conditions will be covered subject to policy wordings and exclusions. I am converting from another group plan which terminated on _____
(Day/Month/Year)

My previous insurance carrier was _____ Plan # _____

DEPENDENT INFORMATION (include a list of additional dependents if necessary)

	Last Name	First Name	Middle Initial	Gender M / F	Date of Birth Day/Month/Year
Spouse					
1st Child					
2nd Child					
3rd Child					

BENEFICIARY DESIGNATION

I hereby name the following revocable (irrevocable in Quebec) beneficiary(ies) of any Life Insurance benefits payable under this plan. If not specified, the Beneficiary will be the Estate. If any Beneficiary is a minor a Trustee should be named on their behalf.

_____ Last Name _____ First Name/Middle Initial _____ Relationship to Employee

This enrollment form and medical form should be mailed or given to your broker

**(CAUS) Canadian Benefits
Value - Value Plus - Business Value Plan**

BROKER ID **W** _____

- Plan Applying for:** **Value** (Guaranteed Issue) **Value Plus** (Medically Underwritten) **Business Value Plan** (Medically Underwritten)
- Coverage Applying for:** **Single** (Applicant Only) **Couple** (Applicant & Spouse or Applicant & one Dependent) **Family** (Applicant, spouse & Dependents)

Monthly amount to be drawn: _____ or Annual amount _____ (see enclosed Plan information and Price List you are applying for)

Request and Authorization for the Automatic Cheque Plan

I/We acknowledge that this authorization is for the benefit of Advance Benefit Canada Insurance Solutions Inc. and my financial institution and is provided in consideration of my financial institution agreeing to process debits against my account in accordance with the rules of the Canadian Payments Association. I (We) warrant and guarantee that all persons whose signatures are required to sign on this account have signed this agreement below. I (We) hereby authorize Advance Benefit Canada Insurance Solutions Inc. to draw on my account for the following purpose(s): (Insurance Benefits).

Signature of Depositor(s) _____

PRE-AUTHORIZED DEBIT AGREEMENT

1. While the Automatic Cheque Plan is in effect, the mode of payment will be monthly and if the required monthly payments change, a revised statement will be forwarded at least 10 calendar days before the due date to your address of record.
2. This authorization / agreement may be cancelled at any time upon notice being provided by the payor, either in writing, or orally with proper authorization to revoke this authorization. I (We) must provide notice of revocation to Advance Benefit Canada Insurance Solutions Inc.
3. I (We) acknowledge that providing and delivering this authorization to Advance Benefit Canada Insurance Solutions Inc. constitutes delivery by me (us) to my financial institution. Any delivery of this authorization to you constitutes delivery by me (us).
4. I (We) acknowledge that the processing member is not required to verify that a PAD has been issued in accordance with particulars of this PAD Agreement including, but not limited to, the amount. I (We) acknowledge that the processing member is not required to verify 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 or caused to be issued by the payee on the account drawn.
5. Revocation of this authorization does not terminate any contract for goods or services that exists between the payor and the payee. The Payor's PAD Agreement applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
6. A PAD may be disputed by a payor under the following conditions:
 - (i) the PAD was not drawn in accordance with the Payor's PAD Agreement; or
 - (ii) the Payor's PAD Agreement was revoked; or
 - (iii) pre-notification was not received and such notification was required under the terms of the PAD Agreement.

The payor, in order to be reimbursed, acknowledges that a declaration to the effect that either (i), (ii), or (iii) took place, must be completed and presented to the branch of the processing member holding the payor's account up to and including 90 calendar days in the case of a personal PAD or up to and including 10 business days in the case of a business PAD, after the date on which the PAD in dispute was posted to the payor's account.

The payor acknowledges that a claim on the basis that the Payor's PAD Agreement was revoked, or any other reason, is a matter to be resolved solely between the payee and the payor when disputing any PAD after the above time set out.

Where a disputed PAD is in regards to a Funds Transfer, no recourse is provided through the clearing system. The payor should seek reimbursement or recourse from the member payee in the event a PAD is erroneously charged to its account.

PAY BY CHEQUE

The account that Advance Benefit Canada Insurance Solutions Inc. is authorized to draw upon is indicated below. A specimen cheque (or facsimile) if available for this account has been marked "VOID" and attached to this authorization. I (We) undertake to inform Advance Benefit Canada Insurance Solutions Inc., in writing, of any change in the account information provided in this authorization prior to the next due date of the PAD.

Attach copy of Void Cheque here.

PAY BY VISA OR MASTER CARD

Visa Master Card

Number: _____ Expiry Date _____
Day/Month/Year

Name as shown on Credit Card: _____
Please Print

DISCLOSURE ACKNOWLEDGEMENT

The provision of the following information is a requirement of the Financial Institutions Act. Your licensed agent is assisting you in obtaining a Benefits Plan. These plans are underwritten by various Insurance Companies. Your licensed agent has a brokerage or single case agreement under the terms of which, the agent is able to market the products and services of a number of Companies. The agent will receive a commission as a result of the transaction paid by these companies. The Financial Institutions Act prohibits tied selling. Your Agent may use any information received from you to make you aware of other financial products and services that may be of interest.

I confirm that I have read and understand this Disclosure Acknowledgement from my agent, _____ and I consent to the procedures regarding handling of information described in this application.

Date: _____ Client Name: _____ Client Signature: _____

Date of Application: _____ Agent Signature: _____

This enrollment form and medical form should be mailed or given to your broker