

UNISTAR



GROUP INSURANCE
MASTER APPLICATION

850 – 10655 Southport Rd. S.W.
Calgary, AB T2W 4Y1
(403) 297-0252 / 1-800-292-9066



GROUP CLIENT INFORMATION

Applicant's Name: (Full Legal Name) _____

Business Address: _____

City: _____ Province: _____ Postal Code: _____

Mailing Address (if different from above) _____

City: _____ Province: _____ Postal Code: _____

Telephone: (____) _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Nature of Industry: _____

New Group

Amendment

Policy No(s). _____

GROUP POLICY INFORMATION

Effective Date: _____ Renewal Date: _____

Language Preference: English French

Total number of employees to be eligible as of policy effective date: _____

Total number of employees on payroll as of policy effective date: _____

Please describe any participants excluded from coverage under this policy: _____

SUBSIDIARY/AFFILIATED FIRMS INFORMATION

Please list subsidiaries/affiliated firms to be insured and identified in the policy.

1. _____

2. _____

3. _____

4. _____

5. _____



BILLING DIVISION STRUCTURE/INFORMATION

(Complete if more than one division)

Division	Class	Division Name / Class Description	Division - Nature of Industry

If Address for the divisions/classes are different, please complete this section

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____

Division/Class: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone :(____) _____ Ext: _____ Fax: (____) _____

Contact Person: _____ Title: _____

Email Address: _____



ADMINISTRATION INFORMATION

Previous carrier: _____

Number of years in-force: _____ Previous policy number(s): _____

Termination date (of previous carrier): _____

If there was LTD coverage with the prior carrier and LTD is included with this group, it is imperative that the client keep a copy of the LTD contract from their most recent carrier, as it will be used to help with assessment of the pre-existing limitation on any claims that occur in the first two years of the plan.

Hours normally worked: 40 37.5 35 Other: _____

The minimum number of weekly hours a participant must work in order to be eligible for coverage is:

24 hours other (greater than 20 hours), please specify: _____

Are seasonal employees to be insured for coverage under this plan? Yes No

NOTE: Seasonal employees must work 6 out of 12 months to be eligible for coverage.

Are independent contractors to be insured for coverage under this plan? Yes No

NOTE: Certain restrictions in coverage to independent contractors will apply.

Are all participants who are eligible for STD and/or LTD covered by a Worker's Compensation or a similar plan? Yes No

If "no", please provide details.

Are any of the benefits union negotiated? Yes No

If "Yes", please attach a copy of the Union Agreement.

Waiting period :

- For all existing employees (**hired prior to the effective date** of this policy): _____ months*

- For all new employees (**hired on or after the effective date** of this policy): _____ months*

* **NOTE: waiting periods are applied to an employee's date of full time employment**

Is the plan a condition of employment? Yes No

Employee Contributions: All Classes or Specify Class Name: _____

Employee Contribution Level Options:

1. _____% of overall premium
2. _____% by benefit
3. _____ Flat \$ amount by benefit

Life / AD&D	_____	LTD	_____	Health	_____
Dependent Life	_____	STD	_____	Dental	_____



SPECIAL HANDLING OF SPECIFIED PARTICIPANTS

Are there any participants expected to be absent from work because of injury or sickness on the plan's effective date?

Yes No

If yes, complete the following:

<u>Participant's Name</u>	<u>Date Sickness Began or Injuries Occurred</u>	<u>Nature of Absence</u>
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out
		<input type="checkbox"/> STD <input type="checkbox"/> LTD <input type="checkbox"/> Mat Leave <input type="checkbox"/> Leave without pay <input type="checkbox"/> Temporary lay-off <input type="checkbox"/> Strike, lock-out

PREMIUM INFORMATION (completed by Unistar Special Risks Inc.)

Payment Enclosed: Yes No If yes: \$ _____

(If split by division, please provide split)

Division #: _____	Premium: _____	Tax: _____	Total: _____
Division #: _____	Premium: _____	Tax: _____	Total: _____
Division #: _____	Premium: _____	Tax: _____	Total: _____
Division #: _____	Premium: _____	Tax: _____	Total: _____
Total: \$ _____			Total: _____



SALES TAX INFORMATION

1. Does the policyholder have ANY employees in a province that charges Retail Sales Tax?
 Yes No (If Yes, complete sections A and B)

SECTION A

Policyholders are required to pay Ontario Retail Sales Tax on all their premiums unless they have employees who are exempt from the application of this tax.

Application of this tax is exempt for premiums on employees who are:

1. Not ordinarily resident in province where RST applies, or
2. Indians ordinarily resident on a reserve.

If the policyholder has employees who are exempt, please complete the **Retail Sales Tax Blanket Purchase Exemption Certificate**. The Ministry of Revenue requires that Unistar Special Risks Inc. have documentation on file confirming this exemption.

NOTE: If, in the future, the policyholder's answers to these questions change, Unistar Special Risks Inc. must be notified.

REMIT RETAIL SALES TAX ON EMPLOYEE CONTRIBUTIONS TO THE GOVERNMENT.

Date: _____

Business name: _____

Pursuant to Regulation 1013 made under the Retail Sales Tax Act, we will be remitting the Retail Sales Tax collected from our employees in connection with insurance provided to them under Policy No. _____, or in connection with benefits provided under a benefits plan administered by Unistar Special Risks Inc. under Contract No. _____.

Such election will apply for the duration of the policy referred to above during which time Unistar Special Risks Inc. will not be responsible for any Provincial Sales Tax collected but not remitted to the appropriate Minister.

Signature

Name

Title



SECTION B

**RETAIL SALES TAX
BLANKET PURCHASE EXEMPTION CERTIFICATE**

Business name: _____

Business address: _____

RST Vendor Permit No. (if applicable): _____

Unistar Special Risks Inc. Policy/Contract No.: _____

Description of Policy or Benefit Plan: _____

Under the provisions of the Retail Sales Tax Act, the above-named business claims exemption from Retail Sales Tax on insurance premiums paid: (check appropriate box)

- By an employer under a contract of insurance or benefits plan in respect of employees who ordinarily works outside of the province where RST applies or whose salary is ordinarily paid outside the province where RST applies or in respect of former employees who are no longer resident in the province where RST applies.
- Under a contract of insurance or benefits plan in respect of other individuals who are not ordinarily resident of the province where RST applies.
- Under a contract of insurance or benefits plan where the person whose risk is covered is a Status Indian ordinarily resident on a Reserve.

Signature of Authorized Person

Name of Authorized Person (please print)

Date



BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Employee Basic Life	Insurer:	_____	_____	_____	_____
Rate: \$ _____ / 1,000	Benefit Amount:	<input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)
	Non-Evidence Maximum:	\$ _____	\$ _____	\$ _____	\$ _____
	Overall Maximum:	\$ _____	\$ _____	\$ _____	\$ _____
	Reduction:	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65
	Termination:	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Accidental Death & Dismemberment	Insurer:	_____	_____	_____	_____
Rate: \$ _____ / 1,000	Benefit Amount:	<input type="checkbox"/> Matches Life <input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Matches Life <input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Matches Life <input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)	<input type="checkbox"/> Matches Life <input type="checkbox"/> Flat Amount \$ _____ <input type="checkbox"/> Times Earnings _____ (1, 2 or 3)
	Non-Evidence Maximum:	\$ _____	\$ _____	\$ _____	\$ _____
	Overall Maximum:	\$ _____	\$ _____	\$ _____	\$ _____
	Reduction:	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65	<input type="checkbox"/> None <input type="checkbox"/> 50% at age 65
	Termination:	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement

		Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Dependent Life	Insurer:	_____	_____	_____	_____
Rate: \$ _____ / unit	Benefit Amount: - Spouse	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000
	- Child(ren) NB: Coverage is from live birth.	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
	Termination:	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement	<input type="checkbox"/> Age 65 or earlier retirement <input type="checkbox"/> Age 70 or earlier retirement



BENEFIT ADMINISTRATION

		Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Short Term Disability	Insurer:	_____	_____	_____	_____
Rate: \$ _____ / 10	Benefit Amount:	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70%	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70%	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70%	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70%
	Non-Evidence Maximum:	\$ _____ Per week	\$ _____ Per week	\$ _____ Per week	\$ _____ Per week
	Overall Maximum:	\$ _____ Per week	\$ _____ Per week	\$ _____ Per week	\$ _____ Per week
	Benefit Start Dates:	<input type="checkbox"/> 1-4-1 <input type="checkbox"/> 1-8-1 <input type="checkbox"/> 15-15-15	<input type="checkbox"/> 1-4-1 <input type="checkbox"/> 1-8-1 <input type="checkbox"/> 15-15-15	<input type="checkbox"/> 1-4-1 <input type="checkbox"/> 1-8-1 <input type="checkbox"/> 15-15-15	<input type="checkbox"/> 1-4-1 <input type="checkbox"/> 1-8-1 <input type="checkbox"/> 15-15-15
		1 st or 15 th day accident / 4, 8, 15 th day sickness / 1 st or 15 th day if hospitalized			
	Benefit Period:	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks
	Tax Status:	<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

		Class 1	Class 2	Class 3	Class 4
<input type="checkbox"/> Long Term Disability	Insurer:	_____	_____	_____	_____
Rate: \$ _____ / 100	Benefit Amount:	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70% <input type="checkbox"/> _____% of 1 st \$ _____ + _____% of the balance	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70% <input type="checkbox"/> _____% of 1 st \$ _____ + _____% of the balance	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70% <input type="checkbox"/> _____% of 1 st \$ _____ + _____% of the balance	<input type="checkbox"/> 60% <input type="checkbox"/> 66.7% <input type="checkbox"/> 70% <input type="checkbox"/> _____% of 1 st \$ _____ + _____% of the balance
	Non-Evidence Maximum:	\$ _____ Per month	\$ _____ Per month	\$ _____ Per month	\$ _____ Per month
	Overall Maximum:	\$ _____ Per month	\$ _____ Per month	\$ _____ Per month	\$ _____ Per month
	Elimination Period:	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks	<input type="checkbox"/> 17 weeks <input type="checkbox"/> 26 weeks
	Benefit Period:	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65	<input type="checkbox"/> 2 years <input type="checkbox"/> 5 years <input type="checkbox"/> To age 65
	Tax Status:	<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
	3 Month Survivor Benefits Included:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



BENEFIT ADMINISTRATION

If additional benefits are being applied for (e.g. Employee Assistance Plan or Critical Illness) with another insurer, please complete their specific master application (attached) and return it together with this application to Unistar Inc. for processing.

Additional Benefits Required: Yes No

If yes, please specify the benefit: EAP Critical Illness



To apply for Group Insurance:

We, the previously mentioned: _____ (the applicant) apply to Unistar Special Risks Inc. for the group insurance described in this application. We acknowledge and agree that the attached quotation and Appendixes form a part of this application.

We agree that no insurance will take effect until all of the following conditions have been met:

1. This application must be accepted and the effective date approved by Unistar Special Risks Inc. at it's Head Office;
2. A binder premium must be paid; and
3. The minimum participation requirements must be met.

WE DECLARE that all statements, representations and answers made in this application are a consideration for and a basis of the contract(s) of insurance between us and Unistar Special Risks Inc. We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Unistar Special Risks Inc. We agree to give Unistar Special Risks Inc., on request, full information on each participant insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

To amend your Group Insurance:

We, the previously mentioned: _____ (the applicant) apply to Unistar Special Risks Inc. for amendment of our Group Policy Number _____.

We request that insurance be effective: _____.

We acknowledge and agree that the attached quotation forms a part of this application.

We AGREE that:

1. Increases in benefits only take effect when a participant is actively at work. If a dependant is in hospital confined on the date an increase would otherwise take effect, it will not take effect until the date of discharge from hospital.
2. A policy amendment is valid and takes effect as of the effective date approved by Unistar Special Risks Inc. ONLY IF:
 - a) It is made according to the application; and
 - b) It is signed by an executive officer of Unistar Special Risks Inc. and by or for the actuary of Unistar Special Risks Inc.

WE DECLARE that all statements, representations and answers made in this application are a consideration for and a basis of the requested amendment(s). We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of Unistar Special Risks Inc. We agree to give Unistar Special Risks Inc., on request, full information on each participant insured or eligible for insurance, including information required for assessment of claims.

Please complete the date and signature section below.

Signature Section:

Dated at _____ this _____ day of _____ 20 _____
Applicant _____

(PRINT NAME)

(PRINT TITLE)

(PRODUCER'S SIGNATURE)

(APPLICANT'S SIGNATURE)



BROKER INFORMATION

Broker: _____
License No.: _____
Commission Rate: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: (____) _____ Fax: (____) _____
Email Address: _____