

**FIRM APPLICATION
THE NO FRILLS GROUP INSURANCE PLAN**

EMPLOYER INFORMATION

Company Name: _____ Contact Name: _____

Address: _____ City/Town: _____ Province: _____ Postal Code: _____

Email address: _____ Telephone no.: _____ Fax no.: _____

Requested Effective Date: _____ IBC Member: Yes No

Type of Business

Corporation Proprietorship Partnership Other

1. What is the nature of the business? _____

2. How long has the company been in business? _____

3. How many full-time employees? _____

4. What is the number of normal working hours per week for an employee? _____

5. Are there any employees who work less than 30 hours per week? Yes No

6. Is anyone currently disabled? Yes No

7. Is the group currently insured? Yes No If so, what is the name of the carrier? _____

8. Is your firm in active operation 12 months a year? Yes No

9. Are all your employees covered by Workplace Safety and Insurance? Yes No

10. Are all your employees covered by OHIP? Yes No

11. Briefly describe your business: _____

PREMIUMS PAYABLE

Monthly Premium: _____

We request and authorize the Innovative Business Club Group Insurance Plan to arrange automatic deductions from the following account on the 1st of the month:

Name of Bank: _____

Address: _____

City: _____ Province: _____

GENERAL INFORMATION

Membership

Your application cannot be processed unless you are a member of the Innovative Business Club. To keep your policy in force, you must continue to be a member of the Innovative Business Club.

ALSO:

1. Employees in any size person firm: Coverage for each employee is only effective the first of the month following written approval by the company of the evidence of insurability. However, coverage will not be in effect for any applicant until Medical Underwriting has been completed for applicants who were required to submit evidence of insurability.
2. Medical Underwriting means the premium charged and/or benefits offered could be subject to adjustment or modification of coverage based on you or your family's medical background. This will be determined after an evaluation of the information provided on the medical questionnaire.
3. An employee who is not actively at work on a full-time basis, full pay basis, on the effective date of coverage: coverage for that employee will be effective on the first of the month following the date the employee returns to work on a full-time, full pay basis subject to any evidence of insurability requirements.
4. A dependent who is confined to hospital: coverage for that dependent will be effective on the first of the month following the date the dependent is discharged from the hospital.

ADMINISTRATION OF THE PLAN

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.

Signed at: _____ this _____ day of _____ 20__.

President/Owner: _____ Witness: _____

Broker: _____

Underwritten by: **ONTARIO BLUE CROSS/GREEN SHIELD CANADA**

PLAN ADMINISTRATORS:

Countrywide Benefit Administrators
676 Monarch Ave., Unit 13
Ajax, ON L1S 4S2

NOTICE OF PRIVACY AND CONFIDENTIALITY:

The Innovative Business Club and Countrywide Administrators will collect, use and disclose the personal information which you give for the purpose of providing you with insurance services. To protect its confidentiality, access to this information will be restricted to those administrators who are responsible for administration of services, underwriting, or marketing; and for the processing, facilitating and investigation of claims. When necessary, this information may be shared with others such as, but not limited to, medical facilities, insurance companies, or organizations and to any other person you authorize or that is authorized by law. This acknowledges that information may be transmitted by facsimile (fax), e-mail, postal service, courier service or telephone, and we cannot guarantee the security of privacy of the information that is transmitted through these channels. Call us at 905-686-3320 for a copy of our Privacy Statement.