RWAM 1two3 PLAN

FARMERS' MARKETS of Nova Scotia

SAMPLE MASTER APPLICATION

GROUP BENEFITS FOR 1 to 5 EMPLOYEES

1. APPLICANT INFORMATION

☒ Corporation ☐ Partnership ☐ Sole Proprietorship ☐ Other _____

Farmers' Market Inc.
Corporate Legal Name (in full)

123 Main Street
No. and Street

Fred.MacDonald@gmail.com
Business E-mail address

Halifax, N.S
City, Province

A1A 2B2
Postal Code

(902) 111-2222
Business Telephone (include area code)

Fred MacDonald, Owner
Plan Administrator's Name and Title

Business Fax (include area code)

Nature of Business (describe fully) Farmers' Market

No. of years in business 20 years Name(s) of any Affiliates/Subsidiaries No

2. CURRENT GROUP COVERAGE (DO NOT TERMINATE CURRENT COVERAGE UNTIL APPROVAL IS CONFIRMED)

Is this application to replace similar group benefits? ☒ No ☐ Yes, complete the following:

Number of lives currently insured _____ Current benefits _____

Name of Carrier(s)

Planned termination date of existing coverage (Attach details if date differs by benefit)

3. ELIGIBILITY REQUIREMENTS

- Only **permanent** employees, non-seasonal, who are regularly and Actively Working a minimum 24 hours per week are eligible
- **100% participation** of all employees in the '1two3' Plan is required
- Applicant's business must be established and active for a **minimum one year**
- For groups less than 2 lives, all benefits are subject to medical underwriting and all employees must complete a **Medical Questionnaire**. If an employee is declined coverage, the entire group application may be declined.
- LTD benefits is not available.

4. EFFECTIVE DATE & WAITING PERIOD

Coverage Effective Date Must be the 1st of each month (Year / Month / Day) # Lives to be insured: ☐ 1 ☐ 2 ☐ 3 ☐ 4 or ☐ 5

All eligible employees Actively at Work on the Coverage Effective Date are covered immediately, unless otherwise stated.

Waiting Period for new employees: ☐ 3 mos ☐ 6 mos **(Minimum Waiting Period is 3 months continuous employment)**

5. PREMIUM CONTRIBUTIONS

☐ Non-Contributory - Employer pays 100% of all premiums ☐ *Contributory - Employees pay a portion of premiums

***NOTE:** Choose 'Contributory' if **non-taxable** LTD benefits are desired. In order to qualify any disability plan for non-taxable benefits, **all** employees must pay 100% of their disability premiums & applicable taxes.

6. MANDATORY BENEFITS

Life	AD&D	Dependent Life	EHC	Out-of-Province/Canada	Critical Illness
$25,000 NEM = max.	$50,000 NEM = max.	Spouse $5,000 Child $2,500	80% Co-insurance Survivor Benefit – 6 mos Single or Family	60 days / 100% Co-insurance $5 million maximum Emergency Only (no medical referral)	$3,000 Flat coverage For critical medical conditions listed

Life and AD&D volumes reduce by 50% at age 65. All the above coverages terminate at the **earlier** of retirement or maximum age 70, Critical Illness to age 65, if still Actively Working.

EXTENDED HEALTH CARE BENEFITS SUMMARY (All benefits are subject to provisions of the group insurance policy/benefit plan)

Benefit	Maximum
Prescription Drug Plan - Mandatory Generic	$2,500/yr/person, $8 dispensing fee cap
Practitioners	$400/yr/practitioner
Private Duty Nursing	$10,000 lifetime maximum
Hearing Aids	$400/5 yrs
Dental Accident	$2,000 lifetime maximum

Benefit	Maximum
Eye Exams	1 exam/24 mos ($75 maximum)
Orthotics/Orthopedic Shoes	$250/yr
Medical Supplies, Ambulance	No $ limit (Subject to usual & customary)
Cardiac Rehabilitation	$500/yr
Prosthetics	$10,000 lifetime maximum

EHC EXCLUSIONS: Hospital benefit (semi or private); Fertility, smoking cessation, & obesity drugs/treatment; Preventative vaccines

7. OPTIONAL BENEFITS (Optional Benefits also require 100% participation.

Basic & Preventative Dental Care? ☐ No ☐ Yes

- 80% co-insurance, based on the current year's Dental Fee Guide for employee's province of residence
- Maximum $1000 per calendar year, per person
- Recall not more than once every 9 months
- Includes routine oral examinations, bitewing x-rays, scaling, polishing, fluoride applications, fillings, space maintainers, extractions, denture repairs, endodontics, and periodontics (periodontal scaling/root planing 8 units per calendar year)
- Survivor Benefit – 6 months

8. PREMIUM SUMMARY – Cost per month

MANDATORY BENEFITS Life, AD&D, Dependent Life, Out-of-Province/Canada, EHC, CI	Single EHC	Family EHC
	$ 93.16	$ 190.61

OPTIONAL BENEFITS Dental Care Long Term Disability	Single Dental	Family Dental
	$ 40.05	$ 101.95

- Premiums are subject to PST where applicable
- Premiums are reviewed annually with adjustments implemented every January 1st, regardless of Coverage Effective Date
- $10 per month Admin Fee + HST/GST applies

9. MANDATORY PRE-AUTHORIZED DEBIT (P.A.D.) PLAN

- The P.A.D. withdrawal will be processed the 1st day of each month.
- ATTACH A VOID CHEQUE along with the initial month's premium deposit accompanying this application.

<< Sign Attached Pre-Authorized Debit (PAD) Agreement >>

10. APPLICATION TO PARTICIPATE IN THE RWAM TRUST

APPLICANT HEREBY:

1. Applies to become a Participating Employer in the RWAM Group Insurance Trust (the "Trust") and agrees to be bound by the applicable provisions of the Trust and any insurance contracts insofar as they relate to the benefits specifically requested herein. Benefits under the Trust are provided by licensed Insurers under contracts issued to the Trust. RWAM administers the Trust on behalf of its trustees;
2. Agrees, at all times, to enroll only actively working, eligible permanent employees (and their eligible dependents) under the plan;
3. Promises to pay (or cause to be paid) as due, all contributions/premiums and taxes required to provide the benefits contracted for hereunder, and any amendments hereto. Premiums are due in full on the 1st day of each month. Claims payment may be suspended and/or group coverage may be terminated for non-payment;
4. Agrees to immediately notify RWAM in writing of any insured who ceases to be Actively at Work between the date Applicant signs this Application and the Coverage Effective Date; and at any time hereafter while benefit coverage is in force hereunder;
5. Agrees to immediately inform RWAM in writing of any changes to the Contributory or Non-Contributory status of employees' premiums/contributions, including any change affecting the status, for tax purposes, of any benefits provided under the plan;
6. Appoints RWAM as its agent to administer this benefit plan; and to receive notices from the Trust (except notice of default or termination as a Participating Employer);
7. Agrees to cooperate fully with and to allow RWAM access to any records in Applicant's possession or control relating to this Application and the benefits to be provided hereunder; and
8. Declares that all statements, answers and information provided to RWAM related to this Application (including the contents hereof) are full, complete and true.

Subject to this Application being approved by RWAM, this Application shall form part of the contract of group insurance. Application is not complete until RWAM receives this signed Application, a binder cheque for one month's premium, and completed employee enrolment forms. ***Only those specific benefits and features requested herein and approved by RWAM will be provided under the Applicant's plan.*** If approved, benefits will commence as of the requested Coverage Effective Date. RWAM may correct errors or omissions on this document (with a copy to Applicant. RWAM's changes will be deemed to have been accepted by Applicant unless RWAM receives immediate notice to the contrary. Applicant changes to the plan in future will require a signed amendment and RWAM's approval.

Either party may cancel this contract on at least 30 days' prior written notice. Applicant may be charged the full month's premium or a 15 % late notice fee if such notice is not provided.

By signing below, Applicant acknowledges having read this document in its entirety; confirms it understands and agrees with all of the information, terms and conditions set out in this Application; and requests RWAM to arrange for the indicated benefits on the Applicant's behalf.

The initial month's premium deposit of $ N/A (as per Premium Summary) is included with this Application.

Dated at _____ this _____ day of _____ 20_____

Applicant _____
Full Legal/Corporate Name of Group Applicant

Signed X _____ _____
Authorized Signatory for Applicant — Print Name & Title

Signed X _____ _____
Advisor's Signature — Print Name & Agency

Pre-Authorized Debit (PAD) Agreement

Name of Group/Participating Employer Farmers Market Inc.

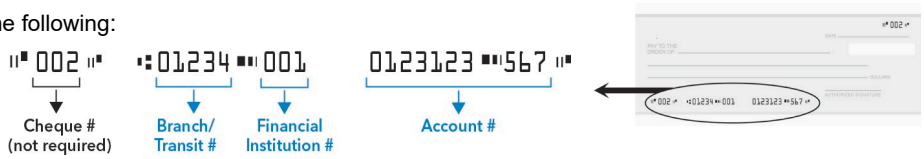
Group # To be Assigned by RWAM Authorized Plan Administrator _____

Authorized Plan Administrator's e-mail for billings Fred. MacDonald@gmail.com

Attach Your Cheque Marked "VOID"

If you do not have a chequing account, we recommend that you confirm the account information you are providing with your financial institution.

If a void cheque is not included, complete the following:



Name(s) of Account Holder (as it appears on the cheque) _____

Name & Address of Financial Institution _____

Financial Institution # ___ ___ ___ (3 digits) Branch/Transit # ___ ___ ___ ___ ___ (5 digits) Account # _____
(If your Acct. # starts with zero, be sure to include the zero. Do not include dashes, hyphens or any other punctuation.)

NOTES:

- If you don't have cheques and are unfamiliar with how to complete the above, contact your financial institution or your Plan Administrator to make sure you are providing RWAM with the correct information. Inaccurate or missing information can result in delays or errors.
- You must be the sole or ***joint*** (generally jointly with your spouse) account holder at a Canadian financial institution & have signing authority.
- Applications for deposit to a third party's account will be rejected.

P.A.D. Authorization:

I authorize RWAM Insurance Administrators Inc. (RWAM) to debit the bank account identified above and/or shown on the attached void cheque for the monthly invoiced premium **(variable amount)** and any applicable taxes **on or about the 1st business day of every month**, for payment of the above named group/participating employer's group employee benefits plan. I understand this authorization may be cancelled by providing written notice to RWAM at the address indicated below, at 30 days prior and no less than 10 days prior to the next scheduled debit.

I have waived the right to pre-notification of at least 10 days before my first PAD; however, RWAM will send me monthly written invoices identifying any new premium amount/rate change at least 5 days before each and any change in the amount of my PAD.

My authorization may be revoked at any time in writing, subject to providing a notice period of 30 days to RWAM. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca.

I understand I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. If I wish to obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

These services are for (check one): ☒ Business Use ☐ Personal Use

Authorized Signature _____ Date _____

Authorized Signature _____ Date _____
If joint account, additional signature required