

ICBA Group Benefits Plan

Company Name _____
Contact Person _____
Address _____
Phone # _____ Nature of Business _____

CORE BENEFITS

Group Life: Flat \$25,000
Accidental Death & Dismemberment: (Same as group Life schedule)
Dependent Life (**mandatory if FAMILY** coverage selected) **Y** (): Spouse - \$10,000/Each Dependent - \$5,000 **OR No** ()
Extended Health: Plan 70. () \$250 deductible, 70% Coinsurance for Drugs, Parameds, and Medical Equipment. 100% all other
Vision care: \$100/24 months
1. () \$100 deductible, 80% Coinsurance for Drugs, Paramedical services, and Medical Equipment. 100% all other (Hospital, Out-of-Country/Out-of-Province, Vision care). Vision care max: \$100/24 months
2. () Nil deductible, 90% Coinsurance for Drugs, Parameds, and Med. Equipment. 100% all other
Vision care: \$100/24 months

OPTIONAL BENEFITS

Dental Plans 1. () 80% Basic Services only (includes Periodontics / Endodontics)
2. () 80% Basic, 50% Major, 50% Orthodontic services (Dependent Children only)
3. () 100% Basic, 50% Major, 50% Orthodontic services (Dependent Children only)
Wage Indemnity (WI): () 2/3 weekly earnings to a maximum benefit of \$750 per week
Elimination period: 15-day illness/15-day accident elimination
Long Term Disability (LTD): () 2/3 monthly earnings to a maximum benefit of \$4000 per month

We hereby apply for participation in the **ICBA Employee Benefits Program**, underwritten by The Co-operators Life in accordance with the terms and conditions of the Master Policy # 7727.

Our Cost-sharing instructions are:

Long Term Disability: Employer % _____ Employee % _____
Other Benefits: Employer % _____ Employee % _____
W.I. Benefits: Employer % _____ Employee % _____

Our Authorization for Pre-Authorized Cheque Withdrawal is Attached.

Authorized Signature _____ Date _____

Name & Title _____

Writing Agent _____