HEALTHSURE

ENROLLMENT FORM FOR EMPLOYER

ADMINISTRATOR INFORMATION

Legal company name: _____

☐ Proof of Corporate Identity attached. The coverage cannot be effective without a proof of identity.

Address: _____ Province: _____ Postal code:_____

Phone: _____ Email: _____

Online Administration Access

Administrator: ☐ same as above ☐ as indicated below Billing address ☐ same as above ☐ as indicated below

First name: _____ Last name: _____

Email: _____

SELECTION OF COVERAGE

☐ HealthSure Basic ☐ HealthSure Enhanced ☐ HealthSure Plus ☐ HealthSure Premium (includes CI Insurance for $25,000)

Effective Date (mm/dd/yyyy):_____Renewal Date (mm/dd/yyyy): _____

Premium Contribution (minimum 25% required):_____

Eligibility (all active full-time employees working a minimum of 20 hours per week; or as described):

_____

☐ Critical Illness Insurance for $25,000.

CLASSIFICATION OF ELIGIBLE EMPLOYEES

A class must contain at least two insured lives.

CLASS A (description): _____

Number of employees on payroll:_____ Number of employees to be insured:_____

OR

CLASS B (description): _____

Number of employees on payroll:_____ Number of employees to be insured:_____

CLASS C (description): _____

Number of employees on payroll:_____ Number of employees to be insured:_____

CLASS D (description): _____

Number of employees on payroll:_____ Number of employees to be insured:_____

If the total number of employees does not equal the number of employees to be insured, please explain:

Are there any employees on a contract, consultant, sub-contractor, or seasonal basis applying for coverage?
☐ Yes ☐ No

/!\ If any employee is absent from work due to layoff, please include a separate page indicating the name(s), date(s) laid off and expected date(s) for return to work.

WAITING PERIOD

Waiting period applies to: ☐ future employees only ☐ present and future employees
/!\ New enrollments must be received by MSH INTERNATIONAL no later than 31 days after completion of the waiting period.

Number of months of continuous employment

☐ 1 month. Class A: _____ Class B: _____ Class C: _____

☐ 3 months. Class A: _____ Class B: _____ Class C: _____

☐ ___ months. Class A: _____ Class B: _____ Class C: _____

PREMIUM PAYMENT OPTIONS

Monthly payment options: ☐ Credit Card ☐ Pre-Authorized Debit (PAD)

Annual payment options: ☐ Credit Card ☐ Cheque ☐ Wire Transfer

Credit card information: ☐ Visa ☐ MasterCard

Card number: _____ Expiry date (mm/yy): _____ Cardholder name: _____

I authorize MSH INTERNATIONAL (Canada) Ltd. ("MSH") to debit my account as per the Method of Payment chosen above. Payments will be withdrawn on or around the 1st day of each month for monthly insurance premiums due. I understand this amount may change at a future date as specified in the Policy. MSH will, to the best of its ability, advise me in writing of the revised amount in advance of its effective date. The pre-authorized payment plan may be discontinued by me or MSH upon 30 days written notice. DISHONOURED TRANSACTIONS: MSH will charge a NSF fee per our current bank fee schedule (and charge this amount using the method of payment above). Privileges will be canceled if there are 2 dishonored payments in the same policy year and full premium payment of balance of policy year will be required within 30 days.

Cheque information: Attach a cheque for the first month's premium, payable to MSH INTERNATIONAL (CANADA) Ltd., Attention Accounting Department, 300, 999-8TH Street SW, Calgary, Alberta, Canada T2R 1N7

Wire transfer information

Beneficiary Bank Name: HSBC Bank Canada
Bank Transit Number: 10029
Bank Account Number: 029423260071
Beneficiary Name: MSH International (Canada) Ltd.

Bank ID: 016
Swift Code: HKBCCATT
Bank Address: 407 – 8th Avenue SW Calgary, AB Canada T2P 1E5
Beneficiary Address: Suite 300, 999 – 8th Street, SW Calgary, AB Canada T2R 1N7

Pre-authorization debit (PAD)

Account holder full name: _____

Address: _____ Province: _____ Postal code: _____

Financial institution name: _____ Withdrawal arrangement: ☐ Fixed ☒ Variable

Address: _____ Province: _____ Postal code: _____

Financial institution number: _____ Transit number: _____ Account number: _____

Recourse: You have certain recourse rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your Financial Institution or visit www.cdnpay.ca.

PAD authorization: I/We, as the Account Holder(s), authorize MSH INTERNATIONAL (Canada) Ltd. ("MSH") and the Financial Institution named above or as indicated on the attached VOID cheque, to withdraw variable monthly payments from my/our account, at the branch indicated, for the purpose of collecting premiums and any applicable sales tax and service charges for insurance under this Policy. The PAD amount will be debited from the account indicated above on the 1st day of each month or the next business day. I/we agree to notify MSH in writing if there is any change to the banking information set out above. I/We waive the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/We agree that

MSH will provide written notice of the amount of the PAD at least three (3) calendar days before the first PAD is debited and before any increase to the PAD amount is debited, except when the increase is due to a change in sales tax, service charges, or the increase to the PAD amount is a result of my/our request. I/We may cancel this PAD agreement at any time, subject to providing 30 days' notice to MSH at the address on the bottom of this form. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD agreement at my/our Financial Institution or by visiting www.cdnpay.ca. I/We understand that cancellation of this PAD agreement will not have any effect on the insurance provided on this Policy provided that payment is received when due and is made in accordance with the terms of this Policy. This PAD agreement only applies to the method of payment.

AUTHORIZATION

The Applicant hereby declares that, to the best of the Applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees that (1) such statements and answers shall constitute the Application for and form a part of the Contract, and (2) the insurance shall become effective in accordance with and subject to the Group Policy to be issued to the Applicant but in no case shall it become effective until this Application has been approved by MSH INTERNATIONAL (Canada) Ltd. ("MSH"). In the case of apparent errors and omissions discovered by MSH in this Application, MSH is hereby authorized to amend this Application by noting the change(s), and acceptance of the Group Policy accompanied by a copy of this Application so amended, shall constitute a ratification of such changes or amendments. A photocopy, scan or fax of this authorization is as valid as the original.

Privacy and confidentiality

MSH INTERNATIONAL (Canada) Ltd. ("MSH") recognizes and respects every individual's right to privacy. When you apply for coverage or submit a claim, we establish a confidential file of personal information. We use the information to administer the individual benefit plan under which you are covered. This includes many tasks, such as: determining your eligibility for coverage, enrolling you for coverage, assessing your claims and providing you with payment, managing your claims, verifying and auditing eligibility and claims, underwriting activities, such as determining the cost of the plan, analyzing the design options of the plan, and preparing regulatory reports, such as tax slips. We limit access to information in your file to MSH staff or persons authorized by MSH who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. MSH INTERNATIONAL (Canada) Ltd., your health care provider or other insurance and reinsurance companies may also exchange information when the information is needed to administer your Health Sure plan.

APPLICANT SIGNATURE

☐ I have read the above authorization and declares that, to the best of my knowledge, the statements and answers contained herein are full, complete and true.

Signature main applicant:_____ Date (mm/dd/yyyy):_____

REPRESENTATIVE INFORMATION

If applicable

Broker/agent:_____ Email:_____

Broker/agent signature: _____ Broker address: _____

Company name: _____ Phone: _____

MSH representative: _____ MSH account manager: _____