Allstate BENEFITS

Customer Agreement

Allstate Insurance Company of Canada (AICC)
PO Box 8100 STN T
Ottawa, ON K1G 3H6
Phone: 844-436-1105
Fax: 844-436-1107
www.mybenefits.allstatevoluntary.ca

Group/Account Number ____________ Master Account Number ____________ Effective Date ____________

1. Account Profile

A. Group/Account Name ____________ **B.** Province ____________

C. Type of Business ____________ **D.** Years in Business ____________

E. Physical Address* ____________

City ____________ Province ____________ Postal Code ____________

* Address must be based on province of group policy.

☐ Check this box if the Billing Address is the same as the Physical Address.

F. Contact Person(s):

1. Responsible Officer of Employer ____________

   Title ____________ Phone ____________ Fax ____________

   ☐ If Administrative Contact is the same as Responsible Officer of Employer check here.

2. Administrative Contact Name ____________

   Administrative Contact Email ____________ Phone ____________ Fax ____________

2. Proposed Insureds

A. Eligible Employees

1. Total number of employees eligible for coverage: ____________
2. Eligible Employees are (check all that apply):
   - ☐ Full-time employees who work 20 or more hours per week.
   - ☐ Full-time employees who work 25 or more hours per week.
   - ☐ Full-time employees who work 30 or more hours per week.
   - ☐ Regular part-time employees who work 20 or more hours per week.
   - ☐ Other (explain): ____________

B. Eligible Association / Union Members

1. Total number of members eligible for coverage: ____________
2. Eligible Members are (check all that apply):
   - ☐ Full-time members who work 20 or more hours per week.
   - ☐ Full-time members who work 25 or more hours per week.
   - ☐ Full-time members who work 30 or more hours per week.
   - ☐ Regular part-time members who work 20 or more hours per week.
   - ☐ Other (explain): ____________

3. Describe any class of employees/members to be excluded: ____________

C. New Hire Waiting Period is ______ days after hire date.

New Hire Enrollment Period includes the 31 days following the New Hire Waiting Period.

Coverage for New Hire begins ☐ On the first day of the month following enrollment or ☐ the Next Day

D. Eligible Individuals in the Waiting Period on the policy effective date will:

☐ Complete Waiting Period or ☐ Be eligible immediately

E. Individuals first eligible after the policy effective date may enroll:

☐ Within 31 days of eligibility or ☐ Only at the next Annual Enrollment Period

3. Billing Information

A. Account Name ______________________ Account Number ______________

B. Billing Address ______________________

City ______________ Province ______________ Postal Code ______________

C. Billing Contact ______________________

Telephone ______________ Fax ______________ Email ______________

Enter additional billing location(s):

Billing Address ______________________

City ______________ Province ______________ Postal Code ______________

Billing Contact ______________________

Telephone ______________ Fax ______________ Email ______________

D. Billing Method

☐ Bill to Employer

☐ Account's Designated Payroll Administrator/Service

Name of Account's Designated Payroll Administrator/Service ______________________

4. Group Insurance

A. Subsidiaries to be included in coverage:

Name	Address	City	Province	Postal Code

Number of Employees ______________ Wholly-owned Subsidiary of Policyholder?* ☐ Yes ☐ No

B. **Requested Effective Date for Plan year** ______________ to ______________ First Payroll Deduction Date ______________

C. Will this replace similar group coverage? ☐ Yes ☐ No If yes:

Termination date of similar plan ______________ Name of similar insurer ______________

D. Is the policyholder discontinuing a previous voluntary insurance program? ☐ Yes ☐ No

If yes, name of prior insurer and product types ______________________

***If the "subsidiary" is not owned by the Policyholder, please describe the relationship under item 5, "Comments".**

5. Comments

Item #	Additional Information
01	
02	
03	
04	
05	
06	
07	

6. Account Agreement

A. Electronic Acceptance of Allstate Insurance Company of Canada Products

By checking the "Yes" box below, you agree to electronic delivery of the certificate of insurance and its accompanying notices ("the Certificates"). If electronically delivered, insureds will be provided instructions on how to receive their Certificate.

To electronically receive their Certificate, insureds will need a personal computer with internet access and appropriate browser software, and Adobe Acrobat Reader®.

☐ YES, I agree to have insureds receive their Certificate electronically via the internet.

☐ NO, I prefer for insureds to receive paper copies of their Certificate.

B. Acceptance of Voluntary Insurance

Upon the approval of Allstate Insurance Company of Canada, the Account agrees to establish a voluntary insurance program for the benefit of its employees/members. For each employee/member who executes a payroll deduction request, we will withhold the amount authorized. We will forward this money directly to AICC upon notice of the premium due from each employee/member.

We may, upon written notice to AICC and to our employees/members, discontinue our participation in AICC's Insurance Program. In such event, the continued payment of premiums will be a matter directly between each employee/member and AICC.

We assume no responsibility for forwarding premiums from anyone other than current employees/members.

We understand that AICC does not disclose personal information about our employees/members to companies or organizations not affiliated with AICC that would use the information to market their own products and services. However, AICC may share with us personal information about our employees/members, and other persons, in order to carry out the purpose of AICC's Insurance Program. Personal Information includes all personally identifiable health information and other information about a person that:

- a person provides to AICC to obtain insurance,
- results from an insurance transaction, or
- is otherwise obtained in connection with providing insurance.

We agree not to disclose or use this personal information except as necessary for our participation in AICC's Insuranc Program. We may be provided access to this information in electronic form and are responsible for limiting this access to those necessary for our participation.

Producer Of Record For Account is: ______________________________

Policyholder Signature:

Authorized Officer - Printed Name ______________________________

Authorized Officer - Signature: ______________________________ Date Signed: ______________

C. Producer Signature

By signing below, I affirm that I have personally met with the Account, verified all of the above information and the Account is ready to be processed.

Producer of Record For Account is: ______________________________

	Agent Number	Name	Signature	Date Signed
Producer of Record				
Servicing Producer				
Other				
Other				

☐ Group Accident

☐ **Employer Paid Plan** **Low Plan** ____ Units
High Plan ____ Units

Coverage Tiers:
☐ EE
☐ EE + CH
☐ EE + SP
☐ FAM

Optional Benefits:
☐ ADD ____ Units
☐ Life Enhancements

Rates Low Plan	
Option 1 (EE)	$
Option 2 (EE + CH)	$
Option 3 (EE + SP)	$
Option 4 (FAM)	$

Rates High Plan	
Option 1 (EE)	$
Option 2 (EE + CH)	$
Option 3 (EE + SP)	$
Option 4 (FAM)	$

☐ **Voluntary Plan** **Low Plan** ____ Units
High Plan ____ Units

Optional Benefits:
☐ ADD ____ Units
☐ Life Enhancements

Rates Low Plan	
Option 1 (EE)	$
Option 2 (EE + CH)	$
Option 3 (EE + SP)	$
Option 4 (FAM)	$

Rates High Plan	
Option 1 (EE)	$
Option 2 (EE + CH)	$
Option 3 (EE + SP)	$
Option 4 (FAM)	$

Employer Contributions **Policyholder** contributes ________ or ____ % of each Employee's/Member's Total Monthly Premium.
Policyholder contributes ________ or ____ % of each Dependent's Unit Total Monthly Premium.

☐ Group Critical Illness (GCI)

☐ **Employer Paid Plan** **Basic Benefit Amount:**
Low Plan $ ________
High Plan $ ________

Coverage Tiers:
☐ EE + CH
☐ EE + SP + CH

Rates Low Plan	
Option 1 (EE + CH)	$
Option 2 (EE + SP + CH)	$

Rates High Plan	
Option 1 (EE + CH)	$
Option 2 (EE + SP + CH)	$

☐ **Voluntary Plan** **Basic Benefit Amount:**
Low Plan $ ________
High Plan $ ________

Rates Low Plan	
Option 1 (EE + CH)	$
Option 2 (EE + SP + CH)	$

Rates High Plan	
Option 1 (EE + CH)	$
Option 2 (EE + SP + CH)	$

Covered Conditions	☐ Essential Plan	☐ Comprehensive Plan
Carcinoma In Situ		
Invasive Cancer		
Heart Attack		
Stroke		
Kidney Failure		
Major Organ Failure (Transplant or Waiting List)		
Alzheimer's Disease		
Parkinson's Disease		
Amyotrophic Lateral Sclerosis (ALS)		

Covered Conditions	Essential Plan	Comprehensive Plan
Coronary Artery Bypass Surgery	N/A	
Multiple Sclerosis	N/A	
Paralysis	N/A	
Deafness	N/A	
Blindness	N/A	
Aortic Surgery	N/A	
Benign Brain Tumour	N/A	
Coma	N/A	
Severe Burns	N/A	
Loss of Speech	N/A	

Optional Benefits: ☐ 2nd Event Critical Illness Benefit and Evaluation Benefit Rider

Optional Benefits for Employer Paid Plans Only: ☐ Benefit Reduction at Age 65 ☐ Termination of Coverage at Age 70

Employer Contributions **Policyholder** contributes ________ or ____ % of each Employee's/Member's Total Monthly Premium.
Policyholder contributes ________ or ____ % of each Dependent's Unit Total Monthly Premium.