HEALTH CARE PROVIDERS
HCP
GROUP INSURANCE PLAN

60 Day Offer

No Medical Questions Asked

Group health and dental benefits for hospital employees

GUARANTEED COVERAGE*

PART-TIME
CASUAL
CONTRACT
TEMPORARY
RETIRING

- New hire not covered by a group health plan?
- Have health coverage through a spouse but don't have long term disability coverage?
- Losing employee benefits? Retiring or transferring from a full time position?

www.healthcareproviders.ca | 1.866.768.1477

What We Offer

SIGNATURE PACKAGE

- Have existing health coverage, working over 18 hours per week and under the age of 65.
- Life, Long Term Disability and ADD&D

SUPREME PACKAGE

- Working over 18 hours per week and under the age of 65.
- Life, LTD and ADD&D plus Health and Dental

STANDARD PACKAGE

- Working less than 18 hours per week or retired, over or under age 65.
- Health and Dental

What You Get

- Options with or without drug coverage
- Option to add dental to all plans at time of enrollment or another time
- Vision care available
- Paramedical services (massage and physiotherapy, psychologist, chiropractor and more)
- Medical items
- Deluxe emergency travel coverage and trip cancellation available with all health plans
- Coverage for semi-private hospital available
- Packages may include Life, Long Term Disability, and Accidental Death Disease and Dismemberment

And more...

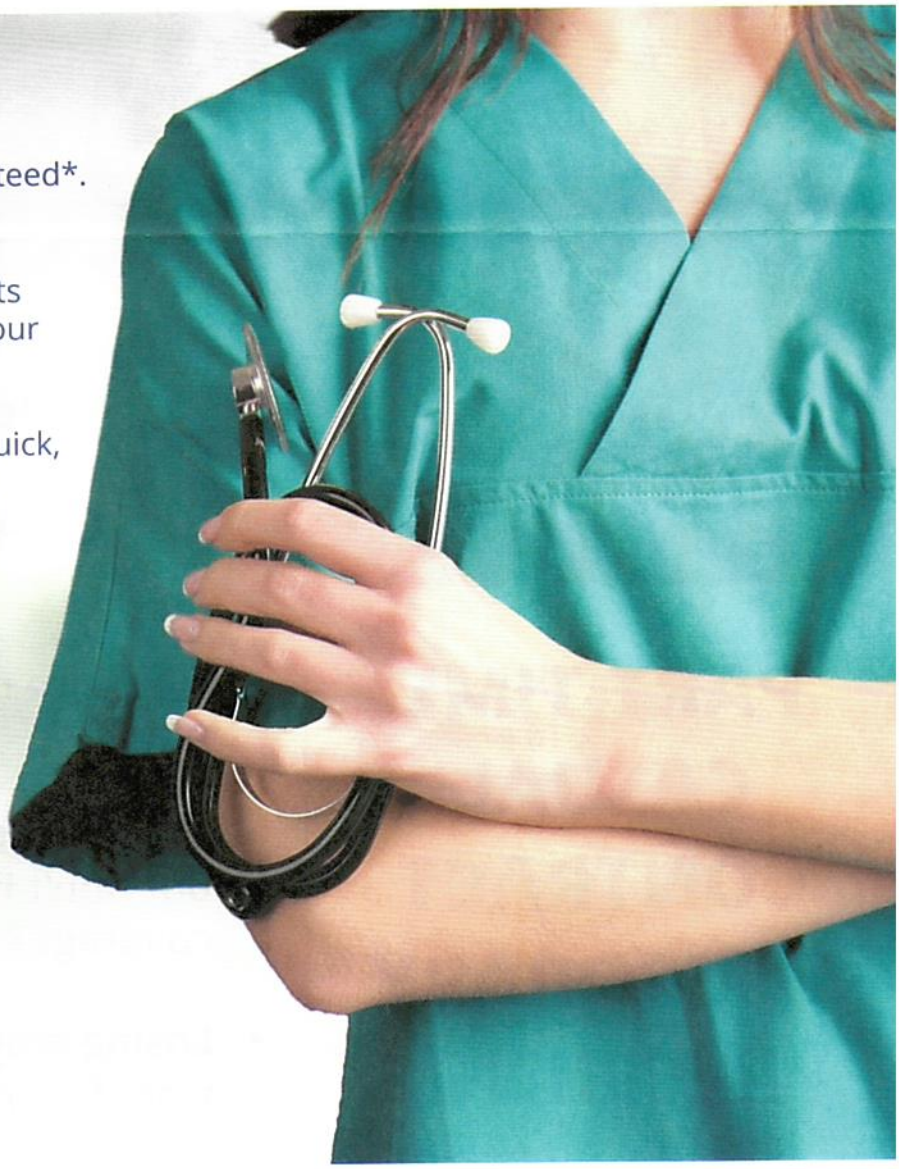
What You NEED To Know

Our Exclusive 60 Day Offer:
Complete and Complete Plus plans guaranteed*.
No medical questions asked.

Lifetime benefits. Health and dental benefits continue regardless of age or changes in your health.

Efficient, hassle-free claims systems with quick, easy access to your benefits, claims status, history and more - anytime, anywhere.

For more information, rates, enrollment forms or to request a custom quote:



*For select plans, some only within a 60 day open window. You must be an eligible employee/retiree of a Canadian hospital and a Canadian resident with valid provincial health insurance. 60 day open window is 60 days from hire (part-time/casual/temporary), loss of full time benefits (transfer to part-time/casual/contract/temporary), full-time retiring from the hospital, full-time permanently laid-off from hospital or losing hospital benefits at age 65.

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

60-DAY OFFER FORM

60

Complete/Complete Plus Eligibility Statement

Please note that in order to be eligible for the GUARANTEED Complete or Complete Plus plan, enrollees must be an employee or retiree of an endorsing Canadian hospital.

New hires: part-time/casual/contract/temp	Full-time retiring from the hospital
Full-time transferring to part-time or casual	Full-time permanently laid-off from hospital
Full-time transferring to temporary or contract	Losing hospital benefits at age 65

Enrollees have 60 days from the first of the occurrences listed above to apply for the GUARANTEED Complete or Complete Plus plan for the employee, their spouse and eligible dependants. To confirm eligibility for the 60-day offer under the Health Care Providers Group Insurance Plan™, the following must be submitted with the employee's enrollment:

A copy of the employee's hospital offer letter or other official documentation outlining their employment status, retirement, or lay-off and the start date of the occurrence.

– OR –

This 60-day offer form completed, signed and dated by an authorized human resources professional at their hospital of employment.

To Be Completed By Human Resources Personnel Only

Employee Name: _____ (First Name/Last Name) **Hospital:** _____ (Hospital Network/Site Name)

New Employee: ☐ Part-Time ☐ Casual ☐ Temporary ☐ Contract

Start Date: _____ (MM/DD/YYYY)

Full-Time Transfer To: ☐ Part-Time ☐ Casual ☐ Temporary ☐ Contract

Transfer Date: _____ (MM/DD/YYYY)

Full-Time Employee: ☐ Retiring ☐ Permanently Laid Off ☐ Losing Benefits @ Age 65

Occurrence Date: _____ (MM/DD/YYYY)

_____ (HR Initials) By initialing, I certify that the above listed employee is losing their benefits after having been actively employed immediately prior to the occurrence dated above.

By signing and dating this 60-day offer form, I certify that the information detailed on this form regarding both the employee and corresponding information regarding their employment/benefits status with our organization is correct.

Authorized HR Staff Name: _____ (Please Print)

Authorized HR Staff Signature: _____ (Please Sign)

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

GROUP ENROLLEMENT FORM 1

TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

PART A - Employee/Retiree Contact Information

First Name: _____ Last Name: _____

Middle Initial: _____ Date Of Birth (MM/DD/YYYY): _____ Gender: ☐ Female ☐ Male

Street Address: _____

Apt: _____ City: _____ Province: _____ Postal Code: _____

Phone: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law* (See page 2)

I am covered under a provincial Health Plan (i.e. OHIP card): ☐ Yes ☐ No

PART B - Employment Details

For Employees Only (Current Position)

☐ Part-Time ☐ Casual ☐ Contract ☐ Temporary Date Hired (MM/DD/YYYY): _____

Occupation: _____ Gross Monthly Salary: _____ Average Weekly Hours: _____

Are you currently on maternity, disability or any other kind of leave? ☐ Yes ☐ No

Are you on hospital payroll? ☐ Yes ☐ No Hospital: _____

For Retirees Only

☐ Retired From Hospital Date Retired (MM/DD/YYYY): _____ Hospital: _____

Last Day Actively Worked At The Hospital (MM/DD/YYYY): _____

Did you retire while on a disability or any other kind of leave? ☐ Yes ☐ No

Are you currently collecting ANY long term disability benefits? ☐ Yes ☐ No

PART C - Enrollment Information For Dependants

Any dependants (including spouse) eligible for coverage must be listed below. Student refers to full-time post secondary enrollment of dependant children age 21-25.

Dependants:	First Name:	Last Name:	Gender: (M/F)	Date Of Birth: (MM/DD/YY)	Student: (Y/N)
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					

My dependants are covered under a provincial health plan (i.e. OHIP card): ☐ Yes ☐ No

PART D - Coverage Information

Select Package Level: ☐ Signature ☐ Supreme ☐ Standard

Select Health Plan: ☐ Essential ☐ Essential Plus ☐ Complete ☐ Complete Plus

Select Dental Plan: ☐ No Dental ☐ Basic Dental ☐ Enhanced Dental

☐ **I wish to be considered for the Optimum level of coverage & have included a Statement of Health form (Form 2)**

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

GROUP ENROLLEMENT FORM 1

PART E - Beneficiary Designation (Mandatory for Signature & Supreme Enrollees Only)

Beneficiary: _____ **Relationship To Insured:** _____

Trustee (Must Name A Trustee If Beneficiary Is Under 18 Years of Age)**:** _____

PART F - Declaration For Common-Law Coverage*

I the undersigned, hereby certify that I have been living with _____ since (MM/DD/YYYY) _____ and representing him/her as my spouse or my (common-law) spouse. I further certify that I and/or my (common-law) spouse are solely responsible financially for either of our children claimed for insurance purposes. I further certify that I do not have or do not wish to provide coverage for my legal spouse, if any.

PART G - Proof of Coverage (For Signature Package Enrollees Only)

Are you currently covered under your spouse's (or another group) benefits plan? ☐ Yes ☐ No

Provided By: _____ **Insured Through:** _____

PART H - Payment Information (Mandatory On All Enrollments)

Choose one method of payment for your deposit and first month premium:

☐ Pre-authorized debit (withdrawal from a chequing account)

We require **two cheques (NOT void)** to be submitted with your enrollment and both must be made payable to **HCP Group Insurance.**

☐ E-transfer (HCP will reach out to confirm e-transfer details)

☐ Credit Card ☐ Mastercard ☐ Visa

Name (as it appears on card): _____

Credit Card Number: _____ Expiry: _____

If paying deposit and first month premium by e-transfer or credit card, please attach a void cheque or pre-authorized debit form from your financial institution to your application. *Your account must have chequing privileges.*

I hereby authorize Health Care Providers to arrange automatic deductions from the account provided.

Dated _____ (City/Town) this _____ (Day) day of _____ (Month) 20 _____ (Year)

Signature of Employee: _____

☐ **I'm retired and would like my monthly premium withdrawn on the first of the month**

PART I - Enrollment Acknowledgment

I hereby enroll for the benefit coverage from Health Care Providers Group Insurance Plan™ for which I am eligible, and I authorize the hospital to release my address, phone and income information to the plan administrator if required. I acknowledge all information is complete and accurate. I understand that the health evidence provided by me and my dependants as part of this enrollment may be used by all parties involved in the issuing of my coverage and I hereby consent to such usage on my behalf of myself and any dependants for whom coverage is sought. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims. I understand that coverage is effective on the first of the month following the date that my enrollment is received, unless I elect to delay the effective date one month, provided all the requirements have been met:

- A fully completed, signed enrollment and required premium has been received
- Underwriting approval for instances where underwriting is required
- I continue to meet all eligibility rules

I acknowledge that it is my sole responsibility to inform Health Care Providers Group Insurance Plan™ of any changes in my work hours, status or otherwise in the event that it may affect my eligibility for coverage, and that failure to do so may result in premiums paid when coverage is not required and refunds under these circumstances will not be made.

Date (MM/DD/YYYY): _____ **Signature of Employee:** _____

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

Please send all forms to: HCP Group Insurance Plan, 1032 Brock Street South, Whitby, ON L1N 4L8

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

STATEMENT OF HEALTH OPTIMUM PLAN

2

PART A - General Information (Employee and Dependants)

Please complete the following information for all persons eligible for coverage including yourself, your spouse and all eligible dependants.

Relationship:	Name (First, Last):	Date Of Birth (MM/DD/YYYY):	Height (Ft/In):	Weight (lbs):	Smoker (Y/N):
Employee:					
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					

PART B - Statement of Health Questionnaire

Have you or any of your dependants ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy, naturopathy, etc.) about, been treated for, or had any known indication of any of the following:

	Yes	No
1. Anxiety, depression, insomnia, ADD/ADHD, eating disorders or any other emotional, mood, behavioural or mental health disorders		
2. Alzheimer's disease, dementia, Parkinson's disease, seizures/epilepsy, loss of consciousness, multiple sclerosis, paralysis or any other neurological disorders		
3. Kidney stones, kidney disease, interstitial cystitis, benign prostatic hyperplasia (BPH) or any other kidney, bladder or prostate disorders		
4. Liver disorders, including hepatitis		
5. Infertility, ovarian cyst, PCOS, uterine fibroids, irregular meses, menopause or any other reproductive or breast disorders		
6. Crohn's disease, ulcerative colitis, irritable bowel syndrome, ulcer, hernia, persistant heartburn/reflux or any other gastrointestinal disorders		
7. Heart disease, stroke/TIA (mini-stroke), heart attack, irregular heartbeat, angina, high blood pressure, elevated cholesterol or any other circulatory, heart or vascular disorders		
8. Alcoholism or drug dependency		
9. Skin disorders, including acne, rosacea, psoriasis or eczema		
10. HIV, AIDS, ARC (AIDS related complex), or any other immunological disorders		
11. Arthritis, osteoporosis/osteopenia, back pain, joitn pain, muscle pain, fibromyalgia or any other joint, bone or muscular disorders		
12. Allergies, asthma, COPD, chronic bronchitis, emphysema or any other respiratory, sleep apnea or lung disorders		
13. Chronic headaches or migraines		
14. Basal cell carcinoma, growths, polyps, tumors, leukemia or any other cancers		
15. Cold sores, herpes or any other sexuall transmitted diseases or infections (STDs or STIs)		
16. Diabetes/elevated glucose, hypothyroidism, hyperthyroidism, adrenal fatigue or any other endrocrine, hormonal or thyroid disorders		
17. Glaucoma, cataracts, Meniere's disease or any other eye, ear or balance disorders		
18. Anemia or blood disorder		
19. Any other condition, disease, disorder or injury not listed above		
20. Have you or any of your dependants ever been treated or hospitalized for or had any known indication or any physical impairment, condition, disease or disorder not stated above?		
21. Are you or any of your dependants currently taking prescription or non-prescription medications of any kind or been advised by a physician or alternative health care provider to take medication of any kind?		
22. Have you or any of your dependants ever been advised to have an investigation, hospitalization or surgery which has not yet been completed?		
23. Have you, your spouse or any listed dependant children been hospitalized in the last 2 years?		

If you answered yes to any of the questions above, please provide additional details on the overpage, and circle which diagnosis or disorder applies to you or your dependants.

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

STATEMENT OF HEALTH OPTIMUM PLAN

2

PART C - Further Information Regarding Conditions from Overpage

If you answered yes to any of the questions on the overpage, please fill out the further details in the fields below and indicate the corresponding question number.

Question Number:	Name of Employee/Dependant (First, Last):	Nature of Illness, Injury or Condition:	Date of Onset & Recovery (MM/DD/YYYY):	Type of Medication (DIN) or Treatment:	Approx. Monthly Cost of Medication:	How Often Do You See Your Doctor For Treatment:

Please note that based on your medical history, or that of a listed dependant, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the enrollment which this statement of health is a part of or acceptance of a counter offer.

PART D - Employee Declaration

I hereby declare that all the statements contained in this application for the Health Care Providers Group Insurance Plan™ are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility, or organization which has records of my or my dependants health to release such information to the plan administrator. I understand and agree that the information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand that it is my obligation to inform Health Care Providers Group Insurance Plan™ of a change in my health or that of my spouse or any listed dependant children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Health Care Providers Group Insurance Plan™ reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims. **This form is valid ONLY 30 days from the date it is signed.**

Dated _____ (City/Town) this _____ (Day) day of _____ (Month) 20 _____ (Year)

Signature of Employee: _____

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.

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HEALTH CARE PROVIDERS GROUP INSURANCE PLAN
PLAN MEMBER GROUP HEALTH FORM

Group Health form to be used when Plan Member is applying for:
- Basic Life, AD&D, & Disability
- Optional Group Life Insurance
- Optional Long Term Disability

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To avoid delays, please complete the required information by printing clearly in ink. All questions must be answered or form will be returned.

PLAN MEMBER INFORMATION (To be completed by the Plan Member)

Group 6414 Account 1 Certificate _____ Group Name _____

Plan Member _____ (First Name) _____ (Initial) _____ (Last Name)

Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)

Phone Number: Home (_____) _____ Work (_____) _____ Cell (_____) _____

Date of Birth _____ (MM/DD/YYYY) ☐ M ☐ F Height _____ ☐ ft/in ☐ cm Weight _____ ☐ lbs ☐ kg

Occupation _____ Are you actively at work? ☐ Yes ☐ No If no, why? _____

IF APPLYING FOR ADDITIONAL EMPLOYEE GROUP LIFE COVERAGE, PLEASE COMPLETE THE FOLLOWING SECTION:

Amount of Additional Employee Group Life Insurance being applied for $ _____ (coverage is available in Units of $10,000 to a maximum of $500,000)

Beneficiary _____ (First Name) _____ (Initial) _____ (Last Name) Relationship _____

HEALTH EVIDENCE

1. Have any family members been diagnosed with MS, diabetes, heart disease, high blood pressure, elevated blood fats, cancer, mental illness, HIV, or had a stroke? ☐ Yes ☐ No
   If yes, specify condition/relationship/age at diagnosis _____
2. Have any of your parents, brothers or sisters had any hereditary disorder (i.e.: Huntington's chorea, polycystic kidney disease, etc.)? ☐ Yes ☐ No
   If yes, specify _____
3. Have you ever consulted a physician or Alternative Health Care Provider (including herbalist, acupuncturist, chiropractor or practitioner of homeopathy or naturopathy, etc.) for, or ever had any condition of (please specify which):
   a) Disorder of eyes, ears, nose or throat? ☐ Yes ☐ No
   b) Severe headaches, dizziness, fainting, loss of consciousness, epilepsy, seizures, speech disorders, paralysis, stroke, disorder of brain or nervous system? ☐ Yes ☐ No
   c) Nervous disorders, including depression, anxiety or suicidal thoughts? ☐ Yes ☐ No
   d) High blood pressure, palpitation or pain about the heart or chest, difficult breathing, cardiac disorders, angina or coronary disease, rheumatic fever, heart murmur, heart attack or other disorder of heart or blood vessels? ☐ Yes ☐ No
   e) Persistent cough or hoarseness, coughing of blood, asthma, emphysema, pleurisy, bronchitis, tuberculosis, respiratory disease or other disorder of the lungs? ☐ Yes ☐ No
   f) Ulcer of stomach or duodenum, recurrent indigestion, jaundice, gall stones, colitis, bleeding or chronic diarrhea, disorders of stomach, gall bladder, liver, intestines, pancreas, rectum, or digestive system? ☐ Yes ☐ No
   g) Hepatitis A, B, C, or "type unknown"? ☐ Yes ☐ No
   h) Albumin, sugar, pus or blood in urine, diabetes, kidney stone or colic, or any other disorder of kidney or bladder? ☐ Yes ☐ No
   i) Arthritis, gout, rheumatism, sciatica, deformity or disorder of joints or limbs, any disorder of the muscles or spine, including degenerative disc disease, pain in neck or back, trauma to spine, use of brace or cervical collar, fibromyalgia or chronic fatigue syndrome? ☐ Yes ☐ No
   j) Leukemia, anemia, hemophilia or any other disorder/abnormality of the blood? ☐ Yes ☐ No
   k) Cancer, tumours, enlarged glands (nodes) or skin lesions, cysts or growths, pituitary, adrenals or other glands or unexplained infections? ☐ Yes ☐ No
   l) Thyroid or other endocrine disorders? ☐ Yes ☐ No
   m) Venereal disease or any sexually transmitted disease or disorder of prostate or reproductive organs? ☐ Yes ☐ No
   n) Other than previously listed, have you had any other conditions, illnesses, ailments, diseases, injuries, operations, visited any other doctor or had any diagnostic tests? ☐ Yes ☐ No
4. In the past 10 years have you:
   a) Had or been told you had Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or "AIDS" related conditions? ☐ Yes ☐ No
   b) Received advice or treatment in connection with any of the categories mentioned in (4a)? ☐ Yes ☐ No
   c) Tested positive for antibodies to AIDS (Human T-cell Lymphotropic, TYPE III); HTLV-III virus? ☐ Yes ☐ No

Details of "Yes" answers
Identify question number, indicate applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

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HEALTH EVIDENCE (CONTINUED) To be completed by the Plan Member

5. Has an application for insurance on your life/health ever been declined, rated or modified in any way? ☐ Yes ☐ No
   When? _____
   Why? _____
   Company? _____

6. Do you currently have an individual life policy with Co-operators that has been issued within the last year? ☐ Yes ☐ No
   If yes, Policy # _____

7. Have you applied for or received a pension or Workers' Compensation or disability benefits because of illness or injury? ☐ Yes ☐ No
   When? _____
   Why? _____

8. Have you lost any time from work during the last 12 months because of illness or injury? ☐ Yes ☐ No
   When? _____
   Amount of time? _____
   Why? _____

9. Do you have any condition for which future hospitalization or surgery has been advised or is contemplated? If yes, give details and dates. ☐ Yes ☐ No

10. Are you under observation, taking treatment/medication or receiving advice from any physician or alternative healthcare provider, for any medical or physical condition/symptom not previously disclosed?. ☐ Yes ☐ No
    If yes, provide details _____

11. a) Have you ever had any disease of the breasts, ovaries, cervix or uterus? ☐ Yes ☐ No
    b) Have any pregnancies or labours been abnormal? ☐ Yes ☐ No
    If yes, indicate applicable items. Include date, diagnosis, duration, type and amount of treatment (list name of drug, strength and dosage, if applicable), outcome/result, as well as name and address of doctor consulted.

    c) Are you pregnant? ☐ Yes ☐ No
    If yes, give expected delivery date _____

12. Do you now or have you ever used alcohol? ☐ Yes ☐ No
    If Yes, complete the following
    Frequency of use ☐ # ___ Daily ☐ # ___ Week ☐ # ___ Month
    Date last used _____

13. Have you ever received or been advised to obtain any treatment for alcohol/drug use (including AA membership)? ☐ Yes ☐ No
    If yes, give details and dates: _____

14. Do you now or have ever used non-prescription drugs, hallucinogenic, stimulant, narcotic, sedative or tranquilizing drugs (including marijuana or cocaine)? ☐ Yes ☐ No
    If Yes, complete the following
    Type of drug _____
    Frequency of use ☐ Daily ☐ # _____ Week ☐ # _____ Month
    Date last used: _____

15. Have you ever used any form of tobacco, nicotine products or substitutes (including nicotine patch and gum)? ☐ Yes ☐ No
    If yes, for how long and how many per day? _____

16. Who is your regular family physician?(If none, Walk In Clinic visited) _____
    Address _____ (Street) _____ (City) _____ (Province) _____ (Postal Code)
    Approximate Date Last Seen _____ (MMM/DD/YYYY) Reason/**Outcome** _____

PRIVACY STATEMENT

Co-operators Life Insurance Company Privacy Statement

At Co-operators, we recognize and respect the importance of privacy. When you apply for insurance or open an account with us, we will ask for your consent to collect, use, keep and share your personal information. We will explain what information we need, what we will use it for and who we will share it with. We will open a confidential file to collect, use, keep and share your personal information for the purposes of confirming your identity, reviewing your insurance needs and determining suitability of our products and services for you, assessing your application for insurance, issuing and administering your policy, including assessing and processing claims, administering your investments, meeting our contractual and regulatory obligations, detecting and preventing fraud, and performing business and statistical analysis. We will not share your personal information for other purposes, except with your consent or as required or permitted by law.

We may tell you about products and services that may be of interest to you. You can tell us what information you want to receive from us and you can withdraw your consent at any time. You may access and correct, if needed, the personal information in your file by sending us a request in writing.

We limit access to your personal information to our staff and other people we have authorized who need to use it to perform their duties. This may include our third-party service providers who may use your personal information for processing, storage, analysis and disaster recovery purposes outside of Canada. They could be required by law to give your personal information to courts, governments or regulators outside of Canada. To protect your personal information, we ensure that privacy and security requirements are included in all third-party service provider contracts.

You can find more details about the Co-operators privacy policy at www.cooperators.ca. If you have any questions regarding our privacy policies or about how we collect, use, keep and share your personal information, please contact our Privacy Officer at Co-operators at 1-888-887-7773, or by e-mail: privacy@cooperators.ca

PLAN MEMBER DECLARATION AND AUTHORIZATION

APPLICANT AUTHORIZATION AND CONSENT

I authorize any person or organization who maintains my personal and health records or information to provide Co-operators (or its agents, representatives, and administrators) with my personal and health information for the purpose of underwriting my application for insurance coverage, evaluating my eligibility for any insurance coverage, and adjudicating my insurance claim(s). I authorize Co-operators to release my personal and health information to my physician, the Public Health authorities, and Co-operator's re-insurer(s), when requested. This authorization will remain valid unless I revoke it in writing. A copy of this authorization will be as effective as the original.

APPLICANT ACKNOWLEDGEMENT AND DECLARATION

I understand that Co-operators (or its agent, representatives, and administrators) may ask me to undergo a medical or paramedical examination(s) to evaluate my eligibility for insurance coverage. If I refuse to undergo such examination(s), this may result in the delay or denial of my application for insurance coverage. I acknowledge that any information I disclose in any paramedical or medical examination or on any medical evidence form(s), questionnaire(s) or other statement(s) given as evidence of insurability will form part of my application for insurance coverage. I certify and declare that I have disclosed true, complete, and accurate information on my application for insurance coverage. I understand and acknowledge that a failure to disclose true, complete and accurate information or a misrepresentation of any material fact(s) may result in Co-operators voiding my insurance coverage.

Plan Member Signature _____ Date _____

This form must be received in our office within 60 days of the above date. Otherwise, a new form must be submitted.

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HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

OPTIONAL LIFE & LTD COVERAGE WORKSHEET

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PART A - Optional Life & LTD Coverage Is Available For Signature & Supreme Enrollees Only

First Name: _____ Last Name: _____

Date Of Birth (MM/DD/YYYY): _____ Gender: ☐ Female ☐ Male Smoker: ☐ Yes ☐ No

Phone: _____ Hospital: _____ Gross Monthly Salary: _____

Please fill out this worksheet and submit with your master application (Form 1) and any additional health forms (Form 3, 5 or 6) required when applying for optional benefit coverage offered to eligible applicants of Signature & Supreme packages only. Evidence of good health is required for all optional benefit coverage applications. Rates are subject to change.

PART B - Worksheet for Optional Life Insurance (Employee and Dependants)

Complete the following calculations for all persons applying for additional coverage including yourself, your spouse and your dependants by using rates from overpage.

Relationship:	Name (First, Last):	Unit Rate (See Overpage):	Number of Units:	Monthly Premium:
Employee:				
Spouse:				
1st Child:				
2nd Child:				
3rd Child:				
4th Child:				
			Total (A):	

PART C - Worksheet for Optional Long Term Disability (Employee Only)

Please complete the following calculations for employee only long term disability coverage by using rates from overpage.

Relationship:	Name (First, Last):	Unit Rate (See Overpage):	Number of Units:	Monthly Premium:
Employee:				
NOTE: For those applicants under 35 who are applying for excess LTD, please use the rate of $0 for the first $1000 of additional LTD coverage.			Total (B):	
			Total (A+B):	
			Tax (7% MB - 8% ON):	
			Monthly Total:	

Worksheet Example Optional Life Insurance

Relationship:	Name (First, Last):	Unit Rate (See Overpage):	Number of Units:	Monthly Premium:
Employee:	Jane Smith (Female, 42, Non-smoker)	1.10	10 units	$11.00
Spouse:	John Smith (Male, 45, Non-Smoker)	2.50	5 units	$12.50
1st Child:	Kimmy Smith	0.70	2 units	1.40
			Total (A):	$24.90

Worksheet Example Optional Long Term Disability (Employee Only)

Relationship:	Name (First, Last):	Unit Rate (See Overpage):	Number of Units:	Monthly Premium:
Employee:	Jane Smith (Female, 42)	2.66	5 units	$13.30
			Total (B):	$13.30
			Total (A+B):	$38.20
			Tax (7% MB - 8% ON):	$3.06
			Monthly Total:	$41.26

OPTIONAL LIFE & LTD COVERAGE WORKSHEET

4

Optional Life Insurance (Employee and Spouse)

Optional life insurance for an employee and a spouse can be purchased in units of $10,000 up to a maximum of $500,000. When submitting your application for optional employee and spousal life insurance coverage, please submit **Form 3** for the employee and **Form 5** for a spouse. Please see chart below for monthly unit rates. **Be sure to include the amount being applied for on the forms.**

	Monthly Unit Rates: Smoker		Monthly Unit Rates: Non-Smoker	
Age	Male	Female	Male	Female
Under 30	$1.20	$1.00	$1.00	$0.80
30 - 39	$1.80	$1.50	$1.20	$1.00
40 - 44	$3.00	$2.00	$1.40	$1.10
45 - 49	$5.50	$3.80	$2.50	$1.80
50 - 54	$8.80	$5.80	$4.50	$2.80
55 - 59	$13.30	$8.20	$6.40	$4.00
60 - 64	$18.00	$11.40	$9.90	$7.00

Optional Life Insurnace (Child)

Optional life insurance for a child can be purchased in units of $5,000 at a monthly rate of $0.70, up to a maximum of $50,000 in coverage. When submitting your application for optional life insurance coverage for a child, please submit one **Form 6** per child for whom you wish coverage to be considered. **Be sure to include the amount being applied for on the forms.**

Optional Long Term Disability (Employee Only)

Optional employee long term disability can be purchased in increments of $100.00. It's important to note that you can purchase optional coverage up to 65% of your gross monthly salary up to a maximum of $5,000. This maximum includes the $1,000 of basic LTD coverage offered through the Signature and Supreme packages. For applicants under 35 years of age, you are eligible to receive up to $1000 of excess LTD coverage at no added cost (subject to medical underwriting and evidence of good health).

Please use this chart for monthly unit rates and include **Form 3** along with this worksheet when applying for excess long term disability coverage.

Age	Monthly Cost Per Unit
Under 35 (First $1000)	$0.00
Under 35 ($1000 +)	$1.07
35 - 39	$1.98
40 - 44	$2.66
45 - 49	$3.47
50 - 54	$4.84
55 - 59	$6.32
60 - 64	$5.91

Important Notes

When applying for optional coverage for yourself (the employee), your spouse and/or dependant children, it is important to complete all applicable sections on this worksheet and include all necessary forms with your enrollment.

- ☐ Optional Life Insurance For Employee - Form 3
- ☐ Optional Life Insurance For Spouse - Form 5
- ☐ Optional Life Insurance For Dependant Child - Form 6
- ☐ Optional Long Term Disability For Employee - Form 3

DO NOT include the monthly premium that you've calculated for your optional coverage with your enrollment. This additional monthly amount will be withdrawn automatically from your bank account once coverage has been approved.

PACKAGE ELIGIBILITY

Your package eligibility is determined by your average hours worked and your employment status. All enrollees must be actively at work and not off on any type of leave such as disability or maternity.

SIGNATURE

Eligibility

- Currently covered under another group plan for extended health care benefits
- Work 18 or more hours per week, on average
- Under the age of 65
- Permanent* part-time, or casual employment status

Benefits

- Employee life insurance
- Employee accidental death, disease and dismemberment insurance (ADD&D)
- Employee long term disability benefits (LTD)

SUPREME

Eligibility

- Work 18 or more hours per week, on average
- Under the age of 65
- Permanent* part-time, or casual employment status

Benefits

- Employee life insurance, LTD, ADD&D
- Extended health care benefits
- Dental care benefits (optional)

STANDARD

Eligibility

- Work less than 18 hours per week, on average
- Permanent* part-time or casual, temporary or contract** employment status or retiree

Benefits

- Extended health care benefits
- Dental care benefits (optional)

*Permanent - a position for which there is NO end date. **Temporary or contract - employment which has a set end date at the time of hire. Temporary or contract employees, regardless of hours worked per week, are eligible only for our Standard package.

GUARANTEED COVERAGE

HCP is proud to offer eligible enrollees with 4 levels of GUARANTEED health and dental plans. No medical questionnaire is required regardless of age, time of enrollment, employment at an endorsing hospital or medical history.

Endorsing Hospital?

Yes

60-Day Open Window?

Yes

Complete or Complete Plus Health Plan & Basic Life, LTD, ADD&D*

No

Essential or Essential Plus Health Plan

No

Essential or Essential Plus Health Plan

Basic Life, LTD, ADD&D:

*Employee life insurance, long term disability benefits (LTD) and accidental death, disease and dismemberment (ADD&D) is based on package eligibility.

60-Day Open Window:

Unique 60-day time frame during which an eligible employee will be offered the Complete or Complete Plus health plan with no medical questions asked.

Endorsing Hospital:

A hospital which actively communicates the opportunity for eligible employees and retirees to enroll in the HCP Plan.

60-day open window eligibility includes 60 days from hire (part-time/casual/contract/temporary), loss of full-time benefits (transfer to part-time/casual/contract/temporary), full-time retiring from the hospital, full-time permanently laid-off from hospital or losing hospital benefits at age 65.

For more information, please visit:
www.healthcareproviders.ca

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THE DETAILS

Prescription Drugs: (Pay Direct Drug Card system) Benefits include drugs legally requiring a prescription, diabetic needles and syringes. Pay generic only unless otherwise indicated in the prescription. Benefits do not include smoking cessation products and medication for the treatment of obesity, erectile dysfunction and infertility.

Travel Benefit: Out of province/out of country emergency medical services up to 60 days for each trip; dollar maximum is per CALENDAR year regardless of the number of trips.

Trip Cancellation: Per covered person, per trip included in the overall maximum out of province/out of country.

Hospital Accommodations: Semi-private room in a public general hospital.

Private Duty Nursing: Services of an RN or RPN or LPN or PSW.

Vision: Maximums apply every 24 months based on date of first paid claim. Prescription eye glasses and/or contact lenses and/or laser eye surgery, eye exams (this benefit is only available for residents in provinces that do not cover eye exams under their provincial plan).

Audio: Hearing aids, repairs or replacement parts (maximums apply every 5 years based on date of first paid claim).

Accidental Dental: Accidental injury to natural teeth. Submit accident report immediately.

Medical Items: Includes items such as wheelchair, hospital bed, glucometer and lancets, orthotics, prosthetics, ventilator, pressure gradient stockings etc. Each individual item is scaled to usual customary limits.

Emergency Transportation: Land or air ambulance.

Medical Alert Bracelets: Maximums apply every 2 years based on date of first paid claim.

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

1032 Brock Street South
Whitby, Ontario L1N 4L8

Toll-Free: 1.866.768.1477
Local: 905.668.7450
info@healthcareproviders.ca

www.healthcareproviders.ca
Benefits that work full-time for those who don't

HEALTH CARE PROVIDERS HCP GROUP INSURANCE PLAN

PACKAGES & PLANS

Packages

Included With Supreme & Standard Packages Only

	SIGNATURE*	SUPREME*	STANDARD
Life Insurance †	$10,000	$10,000	X
Long Term Disability †	$1,000/month	$1,000/month	X
Accidental Death, Disease & Dismemberment †	$25,000	$25,000	X

	† GUARANTEED ANYTIME		† GUARANTEED IN A 60-DAY OPEN WINDOW		MEDICALLY UNDERWRITTEN
	Essential	Essential Plus	Complete	Complete Plus	Optimum
Co-Insurance (Drugs)	X	80%	80%	80%	90%
Prescription Drugs	X	$750	$1,000	$2,500	$10,000
Co-Insurance (Extended Health Services)	80%	90%	100%	100%	100%
Travel Benefit	$1,000,000 (100%)	$1,000,000 (100%)	$1,000,000	$1,000,000	$1,000,000
Trip Cancellation	$5,000 (100%)	$5,000 (100%)	$5,000	$5,000	$5,000
Hospital Accommodations	X	X	$3,000	$3,000	$5,000
Private Duty Nursing/PSW	$1,500	$2,500	$5,000	$5,000	$5,000
Psychologist/ Master of Social Work /Psychotherapist	$400 combined	$400 combined	$400 combined	$500 combined	$500 combined
Speech Therapist	$400	$400	$400	$500	$500
Physiotherapist	$400	$400	$400	$500	$500
Podiatrist/Chiropodist	$400 combined	$400 combined	$400 combined	$500 combined	$500 combined
Massage/Chiropractor/ Osteopath/Naturopath/ Acupuncturist/Dietitian/ Occupational Therapist	$400 combined	$400 combined	$400 combined	$500 combined	$500 combined
Vision	$100 (100%)	$100 (100%)	$150	$200	$250
Eye Exam	$65 (100%)	$65 (100%)	$65	$65	$65
Audio	$300 (100%)	$300 (100%)	$400	$500	$750
Accidental Dental	$1,500 (100%)	$1,500 (100%)	$2,500	$2,500	$5,000
Medical Items	$1,500	$1,500	$2,500	$2,500	$5,000
Medical Alert Bracelets	$50	$50	$50	$50	$50
Emergency Transportation	Unlimited (100%)	Unlimited (100%)	Unlimited	Unlimited	Unlimited

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† GUARANTEED - eligibility and open window conditions may apply

For further details on our **Package**

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n into which you are enrolling.

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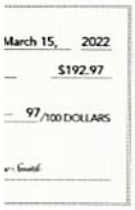
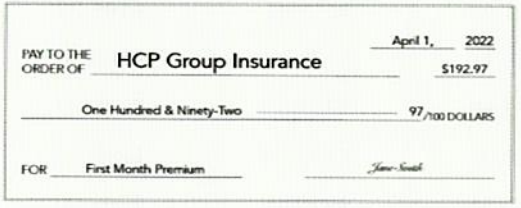
2. First Month Premium

Your first month premium cheque is to be dated for the first of the month in which your coverage will begin. This cheque is **NOT VOID**.

The amount should be equal to the monthly premium for the plan into which you are enrolling. This amount will be used to cover the cost of your first month of coverage under the plan.

Each monthly premium following your first month will be drawn from the same account on your last pay day each month and will cover the following month's coverage.


March 15, 2022
$192.97
97/100 DOLLARS


April 1, 2022
PAY TO THE ORDER OF HCP Group Insurance
$192.97
One Hundred & Ninety-Two 97/100 DOLLARS
FOR First Month Premium

Don't Use Cheques?

making deposit and first month premium payments, ask an
ying your deposit and first month premium payment via an
it a pre-authorized debit banking form with your enrollment.

HEALTH CARE PROVIDERS
HCP
GROUP INSURANCE PLAN

HEALTH CARE PROVIDERS
HCP
GROUP INSURANCE PLAN

PREMIUM GUIDE

1032 Brock Street South
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Benefits that work full-time for those who don't

Premium Guide

Rates are Effective November 1st, 2023 for Residents of Ontario

SIGNATURE

		Under 65
Employee Only	Life Insurance	$31.99
	Long Term Disability	
	Accidental Death, Disease & Dismemberment	

ADDITIONAL LONG TERM DISABILITY AND LIFE INSURANCE OFFERINGS (INCLUDING EMPLOYEE, SPOUSE & CHILDREN) ARE AVAILABLE TO SIGNATURE & SUPREME APPLICANTS*.

SEE FORM 4 FOR RATES AND COVERAGE DETAILS.

*Coverage is subject to medical underwriting & additional monthly premiums

SUPREME

		Rates For Under 65		
		Essential	Essential Plus	Complete
Single	No Dental	$103.06	$131.95	$148.65
	Basic Dental	$155.65	$184.17	$200.87
	Enhanced Dental	$176.28	$205.60	$220.90
Couple	No Dental	$175.26	$234.54	$262.79
	Basic Dental	$269.65	$328.27	$356.52
	Enhanced Dental	$307.01	$367.05	$394.10
Family	No Dental	$204.92	$277.28	$311.41
	Basic Dental	$351.15	$422.49	$456.62
	Enhanced Dental	$408.59	$482.13	$513.85

Employee Life, Long Term Disability and ADD&D Are Included In Supre

STANDARD

		Rates For Under 65					Rates For 65+		
		Essential	Essential Plus	Complete	Complete Plus	Optimum	Essential	Essential Plus	Complete
Single	No Dental	$81.65	$110.54	$127.24	$202.80	$127.24	$67.17	$100.53	$124.24
	Basic Dental	$134.24	$162.76	$179.46	$260.12	$179.46	$131.95	$161.84	$183.94
	Enhanced Dental	$154.87	$184.19	$199.49	$277.14	$199.49	$154.64	$186.56	$206.23
Couple	No Dental	$153.85	$213.13	$241.38	$395.65	$241.38	$132.42	$196.23	$241.72
	Basic Dental	$248.24	$306.86	$335.11	$497.40	$335.11	$248.84	$306.96	$351.20
	Enhanced Dental	$285.60	$345.64	$372.69	$527.97	$372.69	$288.00	$349.27	$392.46
Family	No Dental	$183.51	$255.87	$290.00	$481.86	$290.00	$142.34	$219.04	$272.73
	Basic Dental	$329.74	$401.08	$435.21	$638.34	$435.21	$320.46	$387.76	$442.78
	Enhanced Dental	$387.18	$460.72	$492.44	$684.89	$492.44	$381.44	$454.20	$507.89

All rates listed are paid ***monthly*** and are inclusive of all taxes if applicable in your province of residence. Your coverage and your premium may be affected by changes in your weekly and/or your family status. It is your sole responsibility to make Health Care Providers aware of any such changes at the time of occurrence. Any premium paid towards coverage for wh you no longer required as a result of non-contact at the time of the changes will not be refunded.