Benefits Plus

extended health and dental plan

Extended Health Coverage up to age 75 at 100%

Vision Maximum of $200 every 24 months for eyeglasses, contact lenses, and/or laser eye surgery, and includes eye exams performed by a licensed Optometrist once every 24 months. Clearly Contacts arrangement is included.

Travel Benefits Includes coverage for the first 90 days per trip to a maximum of $5,000,000 for Emergency Services and $50,000 per calendar year for Referral Services.

Emergency Transportation Includes coverage for land or air ambulance to the nearest hospital.

Hospital Accommodation Includes coverage for a semi-private room in a public general hospital.

Private Duty Nursing Maximum of $10,000 per calendar year for the services of a Registered Nurse (R.N.) or Registered Nurses Assistant (R.N.A.) in the home on a full or part shift basis.

Medical Items Includes coverage for prosthetic appliances and durable medical equipment (i.e. orthotics) with physician's referral, as well as replacements, repairs, fittings and adjustments of such devices.

Audio Maximum of $500 once every 5 years for standard hearing aids, repairs or replacement parts. Batteries are not eligible.

Paramedical Services Coverage up to age 75 at 100%

Paramedical Services Maximum of $1,000 per person, per calendar year to a maximum of $60 per visit for Physiotherapist or Certified Athletic Therapist, Chiropractor, Podiatrist/Chiropodist, Osteopath, Naturopath, Speech Therapist/Pathologist, Registered Massage Therapist, and Clinical Psychologist or Master of Social Work. There is a two month waiting period for paramedical coverage. Some services (i.e. registered massage therapy, acupuncture) may require a physician's referral note.

Prescription Drug Coverage up to age 75 at 80%

Prescription Drugs Includes coverage for generic drugs, that by law, require a prescription. Drugs are reimbursed on a pay direct basis at 80% up to a maximum of $2,500 per person, per calendar year. The deductible is an amount equal to the dispensing fee. Costco arrangement is included.

Pre-existing drugs may be excluded from coverage under the plan. Failure to disclose pre-existing drugs (regardless of whether prescription was previously filled) may void your coverage.

Basic & Comprehensive Dental Coverage up to age 75 at 80%

Dental Includes coverage at 80% up to a maximum of $750 for the first 12 months of coverage and $1,500 beginning in the 13th month of coverage and each year thereafter. The deductible is $25 Single/$50 Family per year. All claims are subject to current year's General Practitioners Fee Guide. Coverage includes:

- Recalls once every six months for exams, bitewing x-rays, cleanings and fluoride treatments.
- Complete, general or comprehensive oral exams, full mouth x-rays and panoramic x-rays every 3 years.
- Basic restorations, fillings and inlays.
- Extractions and surgical services. General anesthetics and intravenous sedation only when done in conjunction with eligible extraction's and/or oral surgery. Sleep dentistry is not eligible.
- Endodontic treatment including root canal therapy.
- Periodontal treatment including scaling and/or root planning.
- Standard denture services including relining and debasing of dentures plus denture adjustments after 3 months from installation.

To qualify to enroll, you must be 18 to 60 years of age, working a minimum of 20 hours a week, and covered under your provincial health plan.
Some limitations and pre-authorizations may apply to individual benefits. Please refer to your plan booklet or Member Online Services for full coverage details.

Benefits Plus Plan administered by RPIBI / Bay 4, 5660-10th Street NE, Calgary,AB T2E-8W7 / PH: 1-877-509-3922 / Email: apimm@rpibi.com

application instructions

These instructions are designed to walk you through the application process and to ensure that you are aware of the "fine print". **Please read these instructions carefully!**

▪ *Please print single sided* ▪

Extended Health & Dental Enrollment Form

Applicant Information Please fill out this section in its entirety (and if applicable, attach a copy of your Canadian Work Visa/Permit).

Employment Information For administrative reasons, the employer on the application is always "Benefits Plus".

In this section, please **do not fill out the shaded boxes**. Please **only** fill out the following:

- ✓ Applicant's Earnings
- ✓ Hours Per Week
- ✓ Applicant's Occupation

Leave the remainder of this section blank, *including the employer's signature*.

Please sign and date the form at the bottom of the page.

Health Questionnaire

Applicant Information Please fill out this section in its entirety.

Dependent Information Please fill out this section in its entirety.

Health Questions Please write "yes" or "no" in the space provided in answer to the two medical questions. If you write "yes", please fill out the requested information in the table below.

Please sign and date the form at the bottom of the page.

Pre-Authorized Payment Agreement

Pre-Authorized Chequing (PAC) Agreement Please fill out, sign and date this section if you would like to pay by **automatic bank debit.** Please attach a copy of your void cheque or a PAD form from your bank.

Credit Card Authorization Please fill out, sign and date this section if you would like to pay by **credit card**.

FINE PRINT:

You are purchasing an ***annual*** plan for the health and dental benefits, paid on a monthly basis. There is a one year annual requirement to be on this plan.

Rates are guaranteed to September 1, 2017. Rates and/or benefits are subject to change with thirty (30) days written notice.

Your initial premium payment will be for your first and last months' (2 months) premiums.

If paying by **automatic bank debit**:

- We are charged a $50 fee for any PAC payment that has been returned NSF. It is our policy to recover any NFS fees incurred from the corresponding client.

If paying by **credit card**:

- The description on your credit card statement will read: "CANADIAN CONTRACTOR'S ASSCALGARY AB". Canadian Contractor's Association is our administration company.
- Credit card charges that are returned "declined" are not charged any associated fees.

Please EMAIL your application form (including a copy of your work visa/permit and void cheque, if applicable) to apimm@rpibi.com and mail original documents to RPIBI, Bay 4, 5660-10th Street NE, Calgary, AB T2E-8W7.

Got questions? We are happy to help! Feel free to contact us at the email or phone number below.

Clear Form

Benefits Plus

Extended Health & Dental Enrollment Form

PLEASE PRINT. Submit a PDF copy of the original application and mail the original copy to the address provided.

Applicant Information

Applicant Last Name | **First Name** | **Middle Initial** | **Are you in Canada on a Work Visa/Permit?** *Copy required to enroll in plan. ❑ Yes ❑ No | **Are you covered under your Provincial Health Plan?** ❑ Yes ❑ No

Address | **City** | **Province of Residence** | **Postal Code**

British Columbia

Gender
❑ Male
❑ Female

Language Preference
❑ English
❑ French

Email Address

Date of Birth
Month Day Year

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Common Law*

* Date of Cohabitation _____ (***Date of Cohabitation is mandatory if Common Law**)

Dep. No.	List Dependents Last Name	First Name	Middle Initial	Gender (M / F)	Date of Birth Month Day Year	If child is over 21 years of age and attending school full-time, provide name of school. If child is handicapped, state nature of disability to apply for coverage beyond plan's age limits.
01	Spouse					
02	1st Child					
03	2nd Child					
04	3rd Child					
05	4th Child					
06	5th Child					

Employment Information

Name of Employer

Benefits Plus

❑ **New Applicant**
❑ **Reinstatement**

Applicant's Earnings
$ _____

❑ **Annually**
❑ **Monthly**
❑ **Weekly**
❑ **Hourly**

Hours Per Week
40

Payroll Number (optional) | **Class Code**

Applicant's Occupation

I confirm that this applicant is eligible to apply for coverage and that the information I have provided is true and complete.

Date of Employment (New Applicant) Month Day Year

Date of Rehire Reinstatement) Month Day Year

Effective Date (for administrator use only) Month Day Year

_____ **Authorized Signature of Employer**

_____ **Date**

Applicant Signature

I agree to the conditions of the contract(s) between my employer and the insurer(s) and authorize my employer to deduct required contributions from my earnings. On behalf of myself and my dependents I authorize BBD Inc. and all insurers to exchange the information detailed in this application, and any other benefit related information contained in files regarding me or my dependents, either now or in the future, for the purposes of administration and/or management of the group insurance policies issued by the insurers. I understand that this original document and all other original documents pertaining to me and my dependents are the property of BBD Inc. and will be permanently retained by BBD Inc. as required by the insurers. I confirm that the information I have provided is true and complete.

_____ **Signature of Applicant**

_____ **Date**

Benefits Plus

Health Questionnaire & Pre-Authorized Payment Agreement

PLEASE PRINT. Submit a PDF copy of the original application and mail the original copy to the address provided.

Applicant Information

Applicant Last Name (Dep. No. 00) | **First Name** | **Middle Initial**

Address | **City** | **Province** | **Postal Code** | **Phone Number**

British Columbia

Name of Employer

Benefits Plus

Gender

☐ Male ☐ Female

Applicant's Occupation

Date of Birth — **Month** / **Day** / **Year**

Dependent Information

Dep. No.	Status	Full Name	Gender (M / F)	Date of Birth Month	Day	Year
01	Spouse					
02	1st Child					
03	2nd Child					
04	3rd Child					
05	4th Child					
06	5th Child					

Health Questions

Please answer "yes" or "no" to the following questions: **Yes / No**

1. Have you or your dependents ever had or been treated for heart trouble, high blood pressure, ulcerative colitis, kidney disorder, diabetes, any mental or nervous disorders, alcoholism, lung disorder, cancer, tumors, or joint/limb disorder (including neck/back)?
2. Are you, your spouse, or your dependents taking any prescribed medication? If yes, please provide the name of the medication and reason for use in the spaces provided below.

If "yes" to any of the preceding questions, please provide detailed information below:

Dep. No.	Illness / Condition	Date & Duration	List types of treatment, medications and results (fully recovered or list remaining effects)	Dosage	Monthly Cost

Name & Full Address of Doctor(s) or Hospital(s)

I declare that the statements made herein are true and complete and shall form part of the application for insurance. I understand that any misrepresentation or incorrect information could void my insurance. I hereby authorize your organization, institute or person, including any medical practitioner or medically related facility, insurance company, or the Medical Information Bureau, that may have records or knowledge of me or my health to give the insurer or its reinsurers any such information. A photocopy of this authorization shall be valid as the original. I hereby consent to the insurer procuring or having prepared a consumer report containing personal information about me.

Signature of Applicant **Date**

Pre – Authorized Payment Agreement

1. The Canadian Contractors Association (CCA) is authorized to make scheduled withdrawals to pay the premiums for this policy or policies, against the account at the financial institution or the credit card indicated below or any other financial institution or credit card that the Payor may later designate, in accordance with the rules of the Canadian Payments Association (CPA).
2. I/we acknowledge that this is an **annual plan** for the health and dental benefits, and upon cancellation of this authorization, will ensure that any unpaid portion of the first annual premium is remitted in full immediately.
3. Such withdrawals to pay the premiums for this policy or policies will be made on or about the **1st of each month** and in amounts in accordance with the current premium schedule as issued by the administrator.
4. If the amount of the withdrawal should vary, pre-notification by the Canadian Contractors Association is waived.
5. The financial institution or credit card indicated below is authorized now or at any subsequent time to honour any requests made by the Canadian Contractors Association to withdraw from the account indicated on the VOID cheque or the credit card number provided, including a representment or redraw within 30 days should any withdrawal not clear the account or credit card.
6. If you choose to pay by Pre-Authorized Debit and should a premium payment not clear the account at the financial institution indicated below, or any account that the Payor may later designate, and be returned by the financial institution as non-sufficient funds (NSF), the Payor will be charged the NSF fee that Canadian Contractors Association incurs. **The current NSF fee is $50**.
7. Notification of any change to the account or credit card information provided by the Payor shall be given to the Canadian Contractors Association by the Payor 5 days prior to the next schedule withdrawal. I/We agree that from time to time I/we may authorize the Canadian Contractors Association to deduct such payments from another account upon my/our written instructions.
8. This agreement will terminate in respect of all policies included in it upon 10 written day's written notice by the Canadian Contractors Association or the Payor.
9. A Pre-Authorized Payment (PAP) may be disputed by the Payor under the following conditions (i) If the PAP was not drawn in accordance with this agreement; or (ii) if this agreement was revoked. In the event that either (i) or (ii) applies, the Payor agrees to contact CCA. If a satisfactory resolution cannot be achieved between the Payor and CCA, then in accordance to CPA rules and in order to be reimbursed, the Payor acknowledge(s) that a declaration to the effect that either (i) or (ii) took place, must be completed and presented to the branch holding the account up to and including 90 calendar days in the case of a personal PAP (or up to and including 10 business days in the case of a business PAP), after the date on which the PAP in dispute was posted to the account indicated into the VOID cheque provided. I/We acknowledge that a claim on the basis that hits agreement was revoked, or any other reason, is a matter to be resolved solely between me/us and the CCA, when deputing any PAP after the 90 calendar days in the case of a personal PAP (or up to and including 10 business days in the case of a business PAP.)
10. The name(s) and signature(s) of all persons require to authorized withdrawals from the account indicated below are set out below.

Pre-Authorized Debit Information

(Complete if paying by PAD)

(Please attach a "VOID" cheque)

Name of Bank

Transit # **Institution #** **Account #**

Authorized Signatory **Print Name** **Date**

Authorized Signatory **Print Name** **Date**

Credit Card Information

(Complete if paying by Credit Card)

Card Type

❑ Visa

❑ Master Card

Name of Card Holder **CSC Number**

Credit Card Number **Expiry Date**

Authorized Signatory **Date**