MyCare Health Benefit Option is administered through

**PACIFIC RIM**
**ADMINISTRATION SERVICES LTD.**

MyCare Health Benefit Option

## APPLICATION FORM FOR GROUP CLIENTS

## APPLICANT INFORMATION

**Company Name** _____

**Mailing Address** _____

**City** _____ **Province** _____ **Postal Code** _____

**Phone** Day: _____ Evening: _____ **Email** _____

**Online Admin. Access** First Name: _____ Last Name: _____ Email _____

**Administrator** ☐ Same as Applicant ☐ As indicated below **Billing Address** ☐ Same as Applicant ☐ As indicated below

## ADMINISTRATION INFORMATION (if applicable)

**Contact** First Name: _____ Last Name: _____ Email _____

**Company Name** _____

**Billing Address** _____

**City** _____ **Province** _____ **Postal Code** _____

**Phone** Day: _____ Evening: _____ **Email** _____

## PLAN INFORMATION

**Effective Date:** _____ **Renewal Date:** _____

**Eligibility:** All active full-time employees of the Applicant working a minimum of 20 hours per week; **OR** as described: _____

_____

## CLASSIFICATION

*Classification of eligible employees. A class must contain at least two individuals.*

| CLASS | Description | Number of Employees on Payroll | Number of Employees on MyCare HBO Program | Number of Employees Covered under Worker's Compensation |
|---|---|---|---|---|
| A | All employees | | | |

OR

| | | | | |
|---|---|---|---|---|
| A | | | | |
| B | | | | |
| C | | | | |

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

_____

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

**How many employees (including owners) operate business out of their residence?** _____

**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 (Complete if applicable)

Waiting period applies to: ☐ Future employees only ☐ Present and future employees

***NOTE:*** *New enrollments must be received by Pacific Rim no later than 31 days after completion of the waiting period.*

| Number of months of continuous employment | Class A | Class B | Class C |
|---|---|---|---|
| 1 Month | | | |
| 3 Months | | | |
| Other: _____ Months | | | |



***Continued on reverse.***

## PREMIUM PAYMENT OPTIONS

Note: All Plan fees are subject to Provincial Sales Tax or HST, where applicable.

**MONTHLY payment options:**

☐ **Credit Card** ☐ **PAD** *(Pre-Authorized Debit, complete section below)*

**ANNUAL payment options:**

☐ **Credit Card** ☐ **Cheque** ☐ **Wire Transfer**

**AUTHORIZATION:** *I authorize Pacific Rim Administration Services Ltd. ("Pacific Rim") to debit my account(s) per the Method of Payment chosen above. Payments will be withdrawn on or around the 1st day of each month for monthly Plan fees due. I understand this amount may change at a future date as specified in the contract. Pacific Rim 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 Pacific Rim upon 30 days written notice.*
**DISHONOURED TRANSACTIONS:** *Pacific Rim will charge a $35.00 fee for each dishonoured transaction (and charge this amount using the Method of Payment above). Privileges will be canceled if there are 2 dishonoured payments in the same policy year and full Plan fee payment of balance of benefit year will be required within 30 days.*

**CREDIT CARD:** *Complete the following*

☐ VISA ☐ MasterCard **Card Number** _____ **Expiry Date** (MM/YY) _____

**Cardholder** Name: _____ Signature: _____ **Date** (MM/DD/YY) _____

***CHEQUE:*** *Make cheque payable to **PACIFIC RIM ADMINISTRATION SERVICES LTD.** Attach a cheque for the first month's Plan Fee. You will be billed for the balance once approved.*

***WIRE TRANSFER:*** *Banking transfer details will be provided to you upon receipt of this application form.*

## PAD (Pre-Authorized Debit) Agreement: Complete only if Plan fee payment is made by Pre-Authorized Debit

Attach your VOID cheque **OR** complete the following section:

**Corporation Name** _____

Address _____ City _____ Province _____ Postal Code _____

**Financial Institution Name** _____

Address _____ City _____ Province _____ Postal Code _____

**Branch Number** (5 digits) _____ **Institution Number** (3 digits) _____ **Account Number** (max 12 digits) _____

**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 Pacific Rim Administration Services Ltd. (Pacific Rim) 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 Plan fees and any applicable sales tax and service charges for services under this contract. 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 Pacific Rim in writing if there is any change to the banking information set out above. I/We wave the right to receive pre-notification of the amount to be debited each month and the date of such debit. I/We agree that Pacific Rim 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 Pacific Rim 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 contract. This PAD agreement only applies to the method of payment.

**WITHDRAWAL ARRANGEMENT:** ☐ Fixed ☑ Variable

**AUTHORIZATION:** *I confirm that I am an authorized signing officer for the purpose of completing this Pre-Authorized Debit Agreement on behalf of the corporation.*

**Signature** of Account Holder _____ **Date Signed** (MM/DD/YY) _____

**2nd Signature** (if applicable) _____ **Date Signed** (MM/DD/YY) _____

## PRE-EXISTING CONDITION LIMITATION

**MyCare HBO** is subject to a pre-existing condition clause. A pre-existing condition means a condition for which a Member is given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation during the 24 months prior to the Member's effective date of group membership. Services will not be available for the same medical condition(s) for the 12 months following the effective date of the group membership ***(not applicable to groups with over 50 eligible employees).*** Major exclusions include congenital conditions, chronic conditions and related medical conditions.

## 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 Plan shall become effective in accordance with and subject to the Group Certificate to be issued to the Applicant but in no case shall it become effective until this Application has been approved by Pacific Rim Administration Services Ltd. (Pacific Rim). In the case of apparent errors and omissions discovered by Pacific Rim in this Application, Pacific Rim is hereby authorized to amend this Application by noting the change(s), and acceptance of the Group Certificate accompanied by a copy of this Application so amended, shall constitute a ratification of such changes or amendments. The applicant also acknowledges that the **Pre-Existing Condition Limitation** contained in this application has been read and understood. A photocopy, scan or fax of this authorization is as valid as the original.

Authorized Signatory | Name and Title of Authorized Signatory | Date Signed (MM/DD/YY)

## — FOR BROKER USE ONLY —

Name of Broker | Phone Number | Email Address

**SUBMISSION INSTRUCTIONS: Fax a copy to (604) 293-0344** or **email a scanned copy to apply@pacrim1.com. Send original signed copy of this application by mail to:** MyCare Health Benefit Option, Attn: Application Processing, 215 - 3993 Henning Drive, Burnaby, BC, V5C 6P7.