THRIVE
Flexible Benefits for Retirees

APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND EMERGENCY TRAVEL PLANS

If you have any questions about the Plan, or need assistance completing your application form, please contact the Plan Administrator, Johnson Inc., at 1.866.388.3354 (Option #2) or via email at thrive@johnson.ca.

1. APPLICATION INFORMATION – PLEASE PRINT CLEARLY

First Name(s)	Last Name	Gender ☐ Male ☐ Female
Address (Including Apartment/Unit Number)		Telephone Number ( )
City/Town	Province / Postal Code	Email Address
Date of Birth DAY MONTH YEAR	Provincial Health Care Plan Number	Association Name
Association Name	Membership Number (if applicable)	

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN:

I wish to enrol in the EHC Plan	Indicate status of coverage required
☐ No ☐ Basic ☐ Enhanced[‡] ☐ Superior[‡]	☐ Single ☐ Couple ☐ Family

Are you enrolled in your Province's Pharmacare Plan*? (Applicable to Provinces/Territories where a Pharmacare Program exists.)

☐ Yes ☐ No

***If no, please contact your Province's Pharmacare to enroll in their program as it is a requirement for the Thrive Plan.**

TRAVEL PLAN (only available with EHC):

I wish to enrol in the Travel Plan**	Indicate status of coverage required
☐ No ☐ Basic ☐ Enhanced[‡] ☐ Superior[‡]	☐ Single ☐ Couple ☐ Family

***NOTE: You must enrol in the EHC Plan to elect Travel Plan coverage.*

Indicate status of coverage required

☐ Single
☐ Couple
☐ Family

DENTAL PLAN:

I wish to enrol in the Dental Plan	Indicate status of coverage required
☐ No ☐ Basic ☐ Enhanced[‡] ☐ Superior[‡]	☐ Single ☐ Couple ☐ Family

[‡]NOTE: Once you enrol in the Enhanced or Superior Plan(s), you must remain in the Plan for 24 months.

Check here if you are maintaining coverage in addition to this Plan ☐

Are you the ☐ Member OR ☐ Spouse

NOTE: Coverage for this Plan will become effective the 1st day of the month following the date of receipt of this form.

Insurance Company_____ **Policy Number**_____

If you are not maintaining additional coverage, when transferring from an employer sponsored group insurance plan or your spouse's employer sponsored group insurance plan, you must provide the termination date (in space below). Coverage for this Plan is effective the day after your or your spouse's plan terminates.

Termination Date of Your or Your Spouse's group benefits plan	DAY	MONTH	YEAR

Note: Those with current group benefits coverage may apply within 90 days of losing existing employer coverage. After 90 days of prior plan termination, evidence of insurability is required.

IMPORTANT – YOU MUST COMPLETE AND SIGN SECTION 4 ON THE REVERSE FOR COVERAGE TO BE IN FORCE

If you have selected Couple or Family coverage, please provide Spousal/Dependent Details below:

First Name(s)	Last Name	Gender ☐ Male ☐ Female
Personal Provincial Health Number	**Date of Birth** DAY / MONTH / YEAR	**Dependents age 21+‡** ☐ Full Time Student ☐ Disabled
First Name(s)	**Last Name**	**Gender** ☐ Male ☐ Female
Personal Provincial Health Number	**Date of Birth** DAY / MONTH / YEAR	**Dependents age 21+‡** ☐ Full Time Student ☐ Disabled
‡*If you have Dependent Child(ren) over age 21, please attach the name of school(s) and proof of enrolment or proof of disability.*		
For additional Dependents, please provide information on a separate page.		

3. MONTHLY PREMIUMS PAYMENT

☐ **Automatic Bank Withdrawal**. I have enclosed a **sample cheque marked "VOID"**, along with my **completed PAD agreement**. I authorize Johnson Inc., the Plan Administrator, to make monthly deductions (including mid-term adjustments and arrears) from the bank, trust company or credit union account shown on the cheque. Deductions are withdrawn one month in advance, for example, the August 5th deduction pays for September coverage.

4. CONSENT AND SIGNATURE

I understand that I must be a member of ASSOCIATION/AFFILIATE to maintain the ASSOCIATION/AFFILIATE Insurance Benefits.

I authorize that my premium for this insurance, including any mid policy year adjustments, arrears and renewals, be deducted in monthly amounts due on or after this date of application. I understand that my policy will be automatically cancelled should Johnson Inc. receive two or more Non-Sufficient Funds (NSF) notices on my account.

I recognize that the THRIVE Extended Health Care requires members to be enrolled in their provincial Health Care Program. If you are not already enrolled in your province's Health Care Program, please contact your provincial plan as soon as possible.

I understand Dental coverage will begin on the day Johnson Inc. receives my completed application or on the date prior group coverage terminates if applying during the 90 day eligibility period. I understand EHC coverage will become effective on the later of the date prior group coverage terminates if applying during the 90 day eligibility period, or the date the completed application is approved by the insurer applying as a late entrant.

I also understand that unless I advise Johnson Inc. in writing to the contrary, the coverage I have selected will remain in effect for each policy year thereafter. Johnson Inc. will provide me with notification of my renewal before the beginning of each subsequent policy year, which is April 1.

I authorize my "Association/Affiliate", my "Plan Administrator" Johnson Inc., my "Insurer" Desjardins Financial Security and my "Administrator" Assistel (collectively, the "Providers") to collect, use, maintain and disclose my financial, medical and other personal information, including the information relating to any spouse or dependent who may be the subject of this application, (the "Information") for the purposes of the Extended Health Care, Extended Health Care with Travel Plan and/or Dental Plans (the "Plans") administration and audit and the assessment, investigation, management, processing and/or underwriting of this application and any claims under the Plans (collectively, the "Purposes"). **I authorize** any person with Information, including any medical and health professional, facilities or providers, professional regulatory bodies, any employer, plan administrator, insurer investigative agency and any administrators of other benefits programs to collect, use, maintain and exchange this Information with each other and with the Providers and any replacement Plan Administrator, Insurer, Administrator approved by my Association/Affiliate, for the Purposes. **I understand** that any coverage will not become effective until approved by the Providers. **I authorize** the use of my Provincial health number and any member ID for the purposes of identification and administration.

☐ Please allow my spouse to contact Johnson Inc. to obtain any information regarding this insurance. I agree to allow Johnson Inc. to release and discuss any and all aspects as it pertains to our insurance

I hereby certify that I have completed this application so that all statements made herein are true and correct in all respects and may be relied upon by ASSOCIATION/AFFILIATE without further inquiry.

Signature of Applicant _____ **Date** _____

Signature of Spouse (if Couple or Family coverage selected) _____ **Date** _____

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC. – THRIVE BENEFITS
100 – 17203 103 AVENUE NW
EDMONTON, AB T5S 1J4
thrive@johnson.ca

Desjardins Insurance
LIFE · HEALTH · RETIREMENT

JOHNSON

Johnson Inc. is a licensed insurance intermediary. Johnson administers the Extended Health Care Plan("EHC Plan") and the options for Travel and Dental Care ("Options"). The EHC Plan and Options are underwritten by Desjardins Financial Security ("DFS"). Travel assistance is provided by Assistel. Assistel is a trademark of DFS.

EXPLANATION OF AUTOMATIC BANK DEDUCTION

Automatic Bank Deduction is a convenient way of paying your premium monthly. If you have more than one benefit plan or travel policy with Johnson Inc. ("Johnson") (or home and/or auto insurance policy) and if you are using the same account, all payments will be combined into a single monthly deduction, regardless of the renewal date.

Deductions

Deductions will be withdrawn on the 5th of each month or as a single payment, as applicable, but could be delayed due to processing with your own financial institution. Please note, your first deduction may include premiums to provide coverage from your effective date. Your coverage will remain in place unless you become ineligible or you cancel.

Policy Changes and Premium Changes

A change to a policy, including any renewal, cancellation, addition of new policies or change in coverage(s) can affect the amount of premium owing and likewise the amount of your deduction. Any such change will be explained to you in a Confirmation of Coverage letter. To allow for sufficient processing time, we recommend that any request for change in coverage(s) or cancellation be received in our office by the 15th of the month in order to affect the next billing cycle. If you require further details, don't hesitate to call your Service Supervisor, whose contact information will appear on your documents.

Insufficient Funds / Stopped Payment

When your deduction is withdrawn on the 5th of each month, if it is returned by your financial institution due to Insufficient Funds or Funds Not Cleared, we will attempt to collect the same amount from your account 5-7 business days later. This will give you another opportunity to have the funds available. If, on the 2nd attempt, your deduction is returned by your financial institution, your deduction will be processed as discussed below. Please note, your financial institution may charge you for each unsuccessful withdrawal attempt, depending on your fee plan.

Any deduction that is returned by your financial institution due to Insufficient Funds OR Stopped Payment will be subject to a handling fee. The missed deduction, along with the handling fee, will be collected with your next regular deduction. There are some exceptions for certain coverage, such as Medoc travel insurance, for which a missed deduction and handling fee will be spread equally over the remaining policy term deductions. In the event of multiple missed deductions, your policy may be cancelled by registered mail, in accordance with provincial regulations. You can arrange with your bank to have overdraft protection to prevent insufficient funds.

Important - Changes in Your Bank Account

If you make a change to your financial institution or account, you should advise us by the 15th of the month - this will ensure your next deduction is maintained without interruption. Or, alternatively, you could leave your old account open with sufficient funds until you see the deduction has been cleared.

PERSONAL PRE-AUTHORIZED DEBIT ("PAD") PLAN AGREEMENT

PLEASE COMPLETE THE FOLLOWING REQUIRED INFORMATION (PREPARED IN ACCORDANCE WITH CANADIAN PAYMENTS ASSOCIATION, RULE H1), SIGN AND RETURN, WITH A VOID CHEQUE. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT JOHNSON INC.

- You have chosen to pay your personal benefit plan or travel insurance premium(s) by pre-authorized bank debit ("deduction" or "debit"). If you have more than one benefit plan or travel policy with Johnson Inc. ("Johnson") (or home and/or auto insurance) and if you are using the same account, all payments will be combined into a single monthly deduction, regardless of the renewal date. The deduction may appear on your bank statement as Johnson/Unifund or as indicated below (*).
- I hereby authorize the financial institution designated to debit my account each month for all amounts payable to Johnson related to my benefit plan(s) or travel policy(ies). I understand that any change(s) to my coverage(s), including any renewal or addition of policy(ies), benefits or coverage can affect the amount of premium owing, and likewise will impact the amount of my monthly deduction.
- **Where there is a change to my policy, coverage or benefits, where I have missed a payment, or where I have given instructions to change the amount, I hereby waive the requirement to receive prior written notice of the date and amount of the deduction. However, written notice of any change in the amount of my deduction will be provided to me in all cases and in advance wherever possible.**
- This authority is to remain in effect until Johnson has received written notification from me of change or termination. I can revoke or revise this authorization at any time by providing any such notification by the 15th day of the month in order to take effect on the next scheduled deduction, at the address listed below. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting www.cdnpay.ca.
- **Johnson may assign this authorization to any of its affiliated companies, successors or assigns upon providing written notice to me.**
- I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.
- This is not a contract of or for insurance or benefits. This agreement only applies with respect to the method of payment. Termination of this authorization does not terminate my insurance or benefit contract(s).
- Privacy: I provide consent on behalf of myself and all named insureds under my policy(ies) for the collection, use and disclosure of our personal information for the purposes of communication, assessing my application(s), evaluating claims, detecting and preventing fraud, marketing of other insurance related products and services available, customer surveying, and otherwise as may be required by law. Some of your personal information may be stored and/or processed by one or more service providers outside of Canada. For more information about our policies and practices regarding our use of personal information and of service providers outside of Canada, please contact our Privacy Officer. A full copy of our privacy statement and the contact information of our Privacy Officer is available at www.johnson.ca.

Please Print

Group Name:

Policyholder Name

Street Number: Street Name :

City/Town Province : Postal Code

Phone Number Residential Phone Number Business Extension

Cell Number

For Office Use Only:

Group Number (For office use only):

Member Number (For office use only):

Continued on reverse

*The deduction may also appear on your bank statement as: Servus/Johnson, Meyer's Ins/Johnson Inc., Morgex/Johnson, or Cummings-Cossitt/Unifund.

Please Provide Financial Information (Please Print)

Financial Institution

Street Number : Street Name :

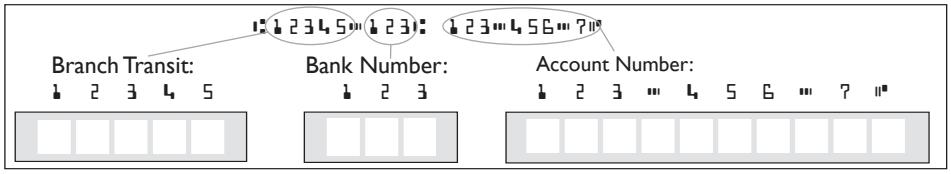
City/Town Province: Postal Code

Account Holder Name

SIGN HERE Account Holder Signature Date *(DD/MM/YYYY)*

For joint account, all depositors must sign if more than one signature is required on cheques issued against the account. If you choose to communicate by email or fax, please be reminded that there is a risk of misdirection or interception in sending personal information by email or fax.

Please Provide Cheque Information As Noted In Example Below



VOID CHEQUE REQUIRED

Group Benefits Administration

Edmonton

Johnson Inc.
100 – 17203 103 Ave NW
Edmonton, AB T5S 1J4
Tel: 780.413.6536
Toll-Free: 1.877.989.2600
Fax: 1.866.226.1430

Langley

Johnson Inc.
9440 - 202 Street, Suite 110
Langley, BC V1M 4A6
Tel: 604.881.8840
Toll-Free: 1.866.799.0000
Fax: 1.866.226.1430

* The deduction may also appear on your bank statement as: Servus/Johnson, Meyer's Ins/Johnson Inc., Morgex/Johnson, or Cummings-Cossitt/Unifund.