APPLICATION FOR EXTENDED HEALTH CARE, DENTAL, AND PRESTIGE TRAVEL INSURANCE PLANS

If you have any questions about the Plan, need assistance completing your application form, or need to submit written notice of change or cancellation please contact the Plan Administrator, Johnson Inc., at 1.877.989.2600 or via email at pbservicewest@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/Territory / Postal Code	Email Address
MPRA Membership Number		MPRA Membership Number (Spouse)
Date of Birth (Day/Month/Year) DD / MM / YYYY	Provincial Health Number	Fair Pharmacare Registration Number

2. PLAN INFORMATION

EXTENDED HEALTH CARE (EHC) PLAN*:

I wish to enrol in the EHC Plan: ☐ Yes ☐ No **Indicate status of coverage required:** ☐ Single ☐ Couple ☐ Family

I am enrolled in a Pharmacare Plan: ☐ Yes ☐ No

Extended Healthcare Coverage Status under Pension Plan (select one):
☐ Yes, I am a recipient of the EHC coverage under the Pension Plan
☐ No, I am **not** a recipient of the EHC coverage under the Pension Plan

Prescription Drug Option (select one):

Plan 1 – If either you or your spouse was born in 1939 or earlier:

☐ Drug Option A: $850 member only*** / $1,200 per household ☐ Drug Option B**: $850 member only*** / $2,500 per household

Plan 2 – If you and your spouse were born in 1940 or later:

☐ Drug Option A: $850 member only*** / $1,500 per household ☐ Drug Option B**: $850 member only*** / $3,500 per household

**NOTE: If your province or territory of residence has a Pharmacare Plan, these insurance coverages are only available if you are enrolled in the Pharmacare Plan.*
***NOTE: Once you enrol in Drug Option B, you must remain in the Plan for 24 months.*
****NOTE: Applicable only to Primary Plan (applicants with EHC coverage under the BC Pension Corporation Pension Plan).*

PRESTIGE TRAVEL INSURANCE (only available with EHC):

I wish to enrol in Prestige Travel Insurance: ☐ **Yes** ☐ **No** If "yes", check the appropriate boxes and complete the details below as required.
NOTE: You must enrol in the EHC Plan to choose Prestige Travel Insurance. Your coverage option (Single, Couple or Family) under Prestige Travel Insurance will match the status of coverage selected under the EHC Plan.

Base Plan (select one):
☐ **62-day Base Plan** ☐ **93-day Base Plan**
This insurance provides an unlimited number of trips within Canada of any duration, and an unlimited number of trips outside Canada of up to 62 or 93 consecutive days, depending on your Base Plan selection.

Deductible Option (select one):
☐ **No Deductible** ☐ **$1,000 Deductible** (save 10% on Base Plan premiums)
Your deductible option can only be changed at the start of each new policy year, September 1st.

☐ **Supplemental Plan** – for a single trip of longer than 93 consecutive days outside of Canada, including the date you leave Canada for a period of more than 93 consecutive days and the date you return to your province or territory of residence.
A 93-day Base Plan is required in order to purchase a Supplemental Plan.

Date of departure from Canada DD | MM | YYYY

Date of return to your home province or territory DD | MM | YYYY

Supplemental Plan premiums are based on the Total Trip Duration increments of 94-98, 99-107, 108-122, 123-137, 138-152, 153-167, 168-182, 183-197 and 198-212 days. For example, a trip of 99 days would have the same premium as a trip of 104 days, as Supplemental Plans have a set premium for a Total Trip Duration ranging anywhere from 99 to 107 days.

DENTAL PLAN:

I wish to enrol in the Dental Plan (80% Basic, 80% Minor, 50% Major): ☐ Yes ☐ No

Indicate status of coverage required: ☐ Single ☐ Couple ☐ Family

Check here if you are maintaining other existing EHC coverage in addition to this Plan*: ☐ **Are you the:** ☐ Member OR ☐ Spouse

Insurance Company: _____ **Policy Number:** _____

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

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

If you are not maintaining additional EHC 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*:	DD	MM	YYYY

NOTE: Those with existing group EHC benefits must apply within 60 days of losing existing employer coverage. After 60 days of prior plan termination, evidence of insurability is required.

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

First Name(s)	**Last Name**			**Gender** ☐ **Male** ☐ **Female**
Provincial Health Number	**Date of Birth** DD	MM	YYYY	**Dependents age 21+** ☐ Full Time Student age 24 or less ☐ Disabled
First Name(s)	**Last Name**			**Gender** ☐ **Male** ☐ **Female**
Provincial Health Number	**Date of Birth** DD	MM	YYYY	**Dependents age 21+** ☐ Full Time Student age 24 or less ☐ Disabled

For additional Dependents, please provide information on a separate page.

3. MONTHLY PREMIUM PAYMENT

☐ **Automatic Bank Withdrawal.** I have enclosed a **sample cheque marked "VOID"**. 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 hereby certify that I am a Member in good standing with the Municipal Pension Retirees' Association and my eligibility ceases upon termination of my MPRA membership.

I acknowledge to be eligible for insurance under the Extended Health Care (EHC) Plan, the Dental Plan and/or Prestige Travel Insurance, I must: a) be a member, or a spouse or dependent of a member; b) be a Canadian resident; and c) be insured under my Provincial or Territorial Health Insurance Plan and **I confirm** that all persons listed on this application are eligible for the selected plan(s). **I also acknowledge** that the EHC Plan requires members to be enrolled in their provincial Pharmacare Program (if applicable).

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 understand that EHC, Dental and Prestige Travel Insurance coverage will begin on the day after my current group benefits terminate OR, if maintaining coverage under my current group plan, on the 1st of the month following the date of receipt of application. If applying as a late applicant, I understand coverage will become effective the date the completed application is approved by the Insurer.

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 before the beginning of each subsequent policy year, which is September 1st.

I authorize my "Group", the Municipal Pension Retirees' Association , my "Plan Administrator" Johnson Inc., my "Insurers" the Manufacturers Life Insurance Company and Royal & Sun Alliance Insurance Company of Canada (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 Plan, Dental Plan and/or Prestige Travel Insurance (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, group 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 Group, 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 Group Member ID for the purposes of identification and administration. For further information on how Johnson Inc. manages your personal information, please visit: https://www1.johnson.ca/protecting-your-privacy. For further information on how Royal & Sun Alliance Insurance Company of Canada manages your personal information, please visit: https://www.rsagroup.ca/your-privacy/privacy-policy.

Signature of Applicant _____ **Date** _____

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

PLEASE FORWARD YOUR APPLICATION TO:

JOHNSON INC.
GROUP BENEFITS ADMINISTRATION
PO BOX 4005 STN A
TORONTO ON M5W 0M7

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 :

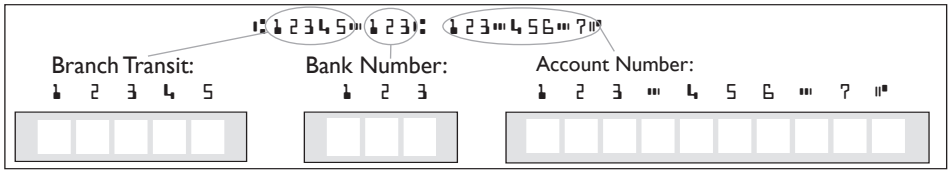
City/Town Province: Postal Code

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

Johnson Inc.
Group Benefits Administration - West
PO Box 4005 STN A
Toronto, ON M5W 0M7
Tel: 780.413.6536
Toll-Free: 1.877.989.2600
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.