enVia VALUE Benefits Program

- 80% Reimbursement
- Health, Dental & more
- No Medicals required

enVia BENEFITS PROGRAM

INDIVIDUAL / FAMILY HEALTH, DENTAL & MORE

An affordable yet comprehensive fully-insured Health or Health + Dental Plan offering **80% reimbursement** up to defined benefit maximums, with **no health evidence required.** See the table on next page for full plan details...

OPTIONAL DISABILITY INSURANCE

After a 30 or 90 day waiting period, a Weekly Disability Benefit of **70% of weekly earnings up to $2,308/week** for 24 months. Thereafter, if Permanently Disabled, a Lump Sum Benefit of **5X Gross Annual Earnings to a maximum of $2,000,000.**

OPTIONAL AD&D

Participants may purchase Accidental Death & Dismemberment coverage in **units of $50,000 up to a maximum of $500,000.** No health evidence is required. Please contact us for separate brochure & application.

QUICK & EASY CLAIMS REIMBURSEMENT

Includes MDM **Pay-Direct Benefits Card**.

THE BENEFITS YOU NEED, AT A PRICE YOU'LL APPRECIATE!

Many types of workers, including Contract, Temporary, Part-time and even some Full-time employees have traditionally been shut out of the Group Health & Dental Benefit plans made available to other working people. Recognizing the need for flexible, comprehensive and affordable benefits protection for this ever-expanding section of Canada's workforce, we're pleased to introduce the **enVia VALUE Benefits Program.**

REAL-WORLD, NEEDS-RELATED COVERAGE OPTIONS

enVia VALUE offers a great combination of the Health & Dental coverage you need and want - at a price you'll appreciate - plus the flexibility of personalizing your coverage with Optional Benefits that are normally only available in large group programs. **No medical exams are required and a Pay-Direct Card is automatically included.**

FLEXIBLE COVERAGE CHOICES

With the **enVia Value Benefits Program**, you can design your benefit coverage to meet your personal needs. Available coverage includes:

- Fully-insured **Individual Health or Health + Dental with Pay-Direct Card**
- **AIG Special Risk Insurance Program with Attaché Services**
- **Workplace Options® Employee & Family Assistance Program**
- Optional **Disability Insurance**
- Optional **Accidental Death & Dismemberment Insurance**

Special Benefit or Insurance Needs? Please contact us, we can help!

Contact us today at toll-free: 1.877.755.9670 or visit www.envia.ca

enVia VALUE Benefits Program - Med 4

Insurers / Administrator	**Co-operators Life Insurance Company, AIG insurance Company of Canada / MDM Insurance Services Inc.**
Eligibility	**Full & Part-time, Self-employed, Contract or Casual workers working at least 20 hours / week (not available in Quebec)**
Health Evidence Required?	**No, Guaranteed Issue! Health evidence required only for Optional Disability. 24 month waiting period for coverage of medications for pre-existing conditions, after which they will be eligible for reimbursment.**
Effective Date	**1st of the month coincident with or next following date of application (or following date of approval by the Insurer of health evidence required for Optional Disability)**

Extended Health Care Benefits: 80% Reimbursement to Plan Maximums, No Deductible

Prescription Drugs (Generic Drug Plan)	• 80% Reimbursement up to $2,000 / calendar year • Exclusions: Anti-smoking, anti-obesity, fertility, lifestyle treatments & medications. • Includes Pay-Direct Health Benefits Card • 24 month waiting period for coverage of prescription drugs related to pre-existing chronic conditions. Applicants must disclose to Insurer any drugs being taken at time of application on a confidential form.
Professional Services	**80% Reimbursement up to $30/visit maximum to a combined maximum of $600 per policy year for all practitioners, including:** Acupuncturist, Chiropractor, Naturopath, Osteopath, Physiotherapy, Podiatrist, Psychologist, Registered Massage Therapist, Speech Therapist.
Accidental Dental	**80% Reimbursement to $2,000 / year maximum**
Ambulance	**80% up to $250 / trip for services not covered by Provincial Health Plan**
Medical Supplies & Services	• **80% reimbursement to $1,500/year for Medical Supplies and to $2,000/year for Medical Equipment and Prothesis** • **Orthotics or Orthopedic Footware 80% to $225/year**
Private Duty Nursing	**80% Reimbursement to a maximum of $3,000 per policy year**
Hospital	**Semi-Private room, 80% Reimbursement to $175/day for 30 days duration**
Vision / Hearing Aids	**Vision Care 80%:** Eye exams $50/24 months; eyeglasses/contacts $100/24 months after 6 month waiting period **Hearing Aids 80%:** up to $350/5 years/person
Maximum per person	**$25,000 per policy year; Overall maximum age limit: Age 70**
Out-of-Country Emergency Hospital / Medical	• **100% reimbursement to $5,000,000 maximum per lifetime for trips of up to 30 days duration** • **includes Emergency Travel Assistance**
AIG Special Risk Insurance	• **Provides $20,000 of Accidental Death & Dismemberment Insurance in Canada on a 24/7/365 basis, plus Attaché Services including Identity Theft Recovery Assistance.**
Workplace Options E&FA	• **Employee & Family Assistance. Provides up to 3 hours per family member of confidential telephonic counselling by professionals for life/work issues and referral for ongoing requirements anywhere in the world.**

Dental: 80% Reimbursement to Plan Maximums, No Deductible

Preventative Services	**80% Reimbursement, max. $700 per policy year;** includes MDM Pay-Direct Health Benefits Card • Level 1 Basic Services with 6 month recall (Diagnostic, Preventative & General services: fillings, extractions & minor surgery, denture repair, rebase & reline.) • Endodontics at 80% and Periodontics at 50% Reimbursement
Major Restorative / Ortho	**Not Included**
Maximum	**80% reimbursement to $700 per person per policy year based on current Provincial Fee Schedule**

Monthly Premium Costs - All Provinces (not available in Quebec)

	EHC Only	EHC + DENTAL
Single	**$79.05**	**$128.63**
Couple	**$146.67**	**$256.33**
Family	**$219.63**	**$364.58**
Single Parent with 1 child	**$121.51**	**$210.76**

Optional Benefits: (Premium rates vary based on age, occupational class and coverage chosen. Separate Health Statement required unless noted)

Disability Insurance	**Both Temporary Total Disability and Permanent Total Disability available. All Disability Benefits Tax-Free.**
AD&D	**Units of $50,000 up to a maximum of $500,000. No health evidence required.**

Note: The premium costs may be adjusted July 1st each year taking into account the overall claims experience of all insured under the Program, as well as inflation and trend costs to reflect the increasing cost of health and dental benefits.

enVia Benefits Program
30 Kelfield Street, Toronto, ON M9W 5A2
1.877.755.9670 toll-free
www.envia.ca

enVia VALUE Benefits Program Application Form - Med 4

Please complete and submit this Application and the attached Electronic Funds Transfer Form and the Chronic Condition Reporting Form. If applying for Optional AD&D or Disability, please contact us for separate brochure & application form. For more information or assistance in completing this application, please visit **www.envia.ca**

Section 1: General Information

Effective Date Requested: _____

YOUR NAME (LAST NAME / FIRST NAME / INITIAL)			MARITAL STATUS
			◯ MARRIED ◯ SINGLE ◯ COMMON-LAW ◯ OTHER _____
DATE OF BIRTH (MM/DD/YYYY)	SEX ◯ MALE ◯ FEMALE	LANGUAGE ◯ ENGLISH ◯ FRENCH	PRIMARY OCCUPATION / ANNUAL EARNINGS

HOME ADDRESS	CITY	PROVINCE	POSTAL CODE

HOME TELEPHONE	WORKPLACE TELEPHONE	FAX

EMAIL ADDRESS	DATE OF HIRE (MM/DD/YYYY)	YOUR EMPLOYMENT STATUS
		◯ OWNER/SELF-EMPLOYED ◯ EMPLOYEE ◯ CONTRACTOR ◯ TEMP

EMPLOYER	BUSINESS ADDRESS	CITY	PROVINCE	POSTAL CODE

YOUR AGENT / BROKER'S NAME (IF APPLICABLE)	AGENT / BROKER'S TELEPHONE:	AGENT / BROKER'S E-MAIL ADDRESS:

AGENT / BROKER'S ADDRESS:	CITY	PROVINCE	POSTAL CODE

Section 2: Coverage Selection & Plan Choice

1. Please indicate your coverage level:

◯ **Single** ◯ **Couple** ◯ **Family** ◯ **Single Parent with 1 child (if more than 1 child, select "Family")**

2. Please indicate the Benefit Coverage you have selected:

Health & Dental Benefits:

◯ **enVia Extended Health Care ONLY** **OR** ◯ **enVia Extended Health Care + Dental**

Use the table below to find the monthly rate for your chosen coverage & marital/family status:

enVia VALUE Program Monthly Rates - All Ages / Provinces (not available in Quebec)

	EHC ONLY	EHC + DENTAL
Single	◯ $79.05	◯ $128.63
Couple	◯ $146.67	◯ $256.33
Family	◯ $219.63	◯ $364.58
Single Parent w/1 child	◯ $121.51	◯ $210.76

Health / Dental Monthly Cost: $_____ / month (a)

Note: There is NO HEALTH EVIDENCE REQUIRED for either EHC or Dental coverage. You must, however, certify any pre-existing conditions on a confidential form as there is a 24 month waiting period from time of application before coverage for pre-existing chronic conditions will commence.

Section 3: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (MM/DD/YYYY)	Child Aged 21-25 (or 25+ if Disabled)
Spouse:				
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED

If a Child is over age 21, state if a Student or Disabled. Students only covered up to age 25 and must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME

☑ **AIG Special Risk Insurance Program (mandatory, automatically included):**

Provides $20,000 of Accidental Death & Dismemberment Insurance in Canada on a 24/7/365 basis, plus Attaché Services including Identity Theft Recovery Assistance.

Beneficiary Designation: (applies to AIG Special Risk Insurance)

○ REVOCABLE ○ IRREVOCABLE

BENEFICIARY(IES) SURNAME(S), GIVEN NAME(S) & INITIAL(S)_____

RELATIONSHIP OF BENEFICIARY TO INSURED_____ **If beneficiary is under age of majority, please complete TRUSTEE section**

I, the undersigned applicant, hereby appoint the person(s) stated as my beneficiary(ies) on my current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future.

Applicant's Signature X_____**Date**_____

DECLARATION APPOINTING TRUSTEE (complete if beneficiary is under age of majority)

I do hereby appoint_____as Trustee to receive any amount due to any beneficiary under the age of majority and declare receipt of such Trustee shall be in good discharge to the insurer for the amount so paid. And I hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at_____**this**_____**day of**_____**20**_____

Applicant Signature_____

☑ **Workplace Options Employee & Family Assistance Program (mandatory, automatically included):**

Provides up to 3 hrs/family member of confidential telephonic counselling by professionals for life/work issues & referral for ongoing requirements anywhere in the world.

Section 4: Calculate your Monthly Cost:

1. **enVia VALUE Extended Health Care ONLY or Extended Health Care + Dental:**
   Enter amount from line (a) on page 1

$_____

Total Monthly Benefits Cost

IMPORTANT:
You must also complete the attached EFT Authorization Form to authorize monthly payments via Pre-Authorized Debit or credit card, and the Chronic Conditions Reporting Form, and Direct Deposit Form for claims reimbursement.

Section 5: Declaration & Authorization

I hereby apply for coverage ("Coverage") under the Health & Dental plan underwritten by **Co-operators Life Insurance Company and AIG Insurance Company of Canada**. **I understand** that certain aspects of such Coverage may extend to my spouse and eligible dependants (collectively, "Dependants"). **I certify** that the information in this form is true and complete to the best of my knowledge. **I acknowledge and agree** that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the willful or negligent provision of false, incomplete, or misleading information. **I authorize** the Program Administrator to collect, use, maintain and disclose personal information relevant to this application ("Information") for the purposes of plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes"). **I am authorized** by my Dependants to consent to this Authorization, on their behalf as if they were signing it themselves, and to disclose and receive their Information, for the Purposes. **I authorize**, as appropriate, either my employer to withdraw from my pay OR the Plan Administrator to withdraw from my financial institution the required insurance premiums, and acknowledge that the amount may vary as my required premium is increased or decreased under this program at the Policy Anniversary. **I agree** a photocopy or electronic version of this authorization is valid. **I designate** the person(s) named above under Beneficiary Designation, as my beneficiary.

I understand that any Information provided to or collected by the Program Administrator in accordance with this authorization, will be kept in a health or disability file. Access to my Information will be limited to:

- Program Administrator employees, representatives, and service providers in the performance of their jobs to the extent required for the Purposes;
- Persons to whom I have granted access; and
- Persons authorized by law.

I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.

X_____

Signature of Applicant (in full) Date (yyyy/mm/dd)

Mail or Fax your completed application to:

enVia Benefits Program
30 Kelfield Street
Toronto, ON M9W 5A2

Toll-free:1.877.755.9670
Fax: 705.721.0352
www.enVia.ca

PRIVATE & CONFIDENTIAL
Pre-Existing / Chronic Condition Reporting Form

Purpose: To report confidentially any chronic or pre-exisiting conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed.

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Insurer and the Administrator, MDM, the provider of the enVia Pay-Direct Card.

Name: _____ Employer: _____

Email: _____ Home Tel: _____ Work or Mobile Tel: _____

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

_____ _____

(Signed) (Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
enVia Benefits Program
30 Kelfield Street, Toronto, ON M9W 5A2

Or FAX this form to: 705.721.0352

If you have any questions or require assistance please contact:
Laurence Allen at: Toll-free 1.877.755.9670; email: info@envia.ca

MDM Insurance Services Inc.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

enVia Benefits Program Invoice Payment

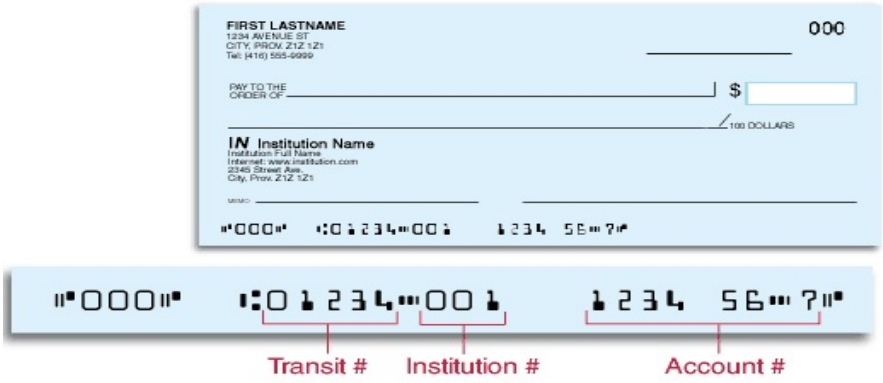
Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Complete (or attach a blank cheque marked "VOID") and return this form to authorize Electronic Funds Transfer (EFT) payment and/or e-mail notification of your invoices.

Name: _____ Policy Number: _____

Name of Financial Institution: _____

Transit #: | | | | | | Institution #: | | | | Account #: | | | | | | | | | | | | |



Payment Method and Notification Options

☑ Monthly Invoicing with EFT withdrawal

☐ Receive an e-mail with your invoice included as a password-protected file attachment.

E-mail Address (please print clearly): _____

Password (must be at least 6 characters): _____

Please return this form to: MDM Insurance Services Inc., P.O. Box 970, Guelph, ON, N1H 6N1 or fax it to: 519-836-4909

I/We hereby authorize MDM Insurance Services Inc. (MDM) through The Bank of Nova Scotia to collect payment of monthly or other periodic billings for services supplied by MDM, by means of Electronic Funds Transfer (EFTs) drawn against my/our account at the financial institution shown on the Authorization form. I/We hereby waive any requirement for pre-notification of changes in the amounts and/or payment dates of EFTs drawn against my/our account at my/our Financial Institution. I/We will notify MDM Insurance Services Inc. in writing of any changes in the account information or termination of this authorization at least thirty (30) days prior to the next payment date. I/We understand that termination of this authorization does not affect my/our obligation to pay funds owing for claim payments, administrative expenses, and applicable taxes.

_____ _____

Authorized Signature Date

_____

(additional signatures if more than one signature is required on cheques issued against the account)

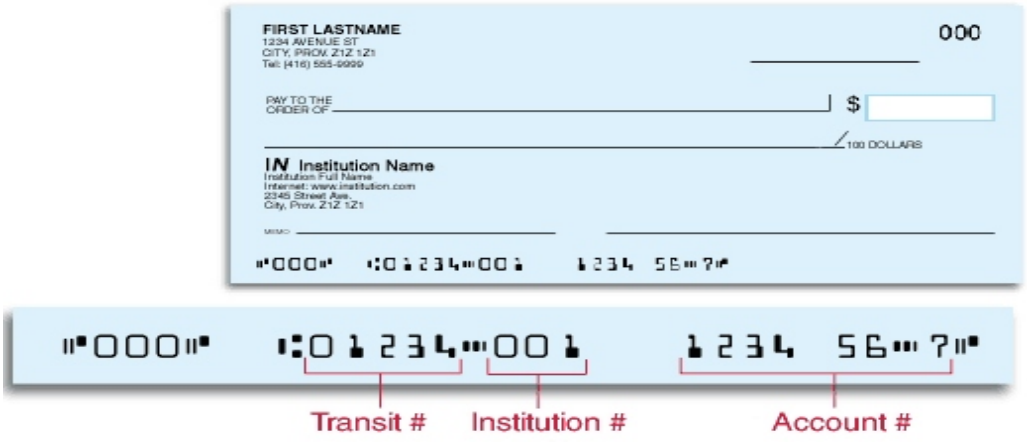
MDM Insurance Services Inc.

DIRECT DEPOSIT APPLICATION

Complete and return this form for direct deposit of claims payment and electronic delivery of your Explanation of Benefits. Please return this form to: MDM Insurance Services Inc., P.O. Box 970, Guelph, ON, N1H 6N1.

Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Employee/Member's Name:	
Group Policy Number:	
Name of Employer:	
Name of Financial Institution:	
Institution Number (3 digits):	
Transit (Branch) Number (5 digits):	
Account Number:	
E-mail Address:	
Employee/Member's Signature:	**Date**:



Providing our office with the above information, you as the account holder, are authorizing MDM Insurances Services Inc. and your financial institution to credit directly to your account your and your eligible dependents (if applicable) Extended Health Care, Dental, Health Spending Account and/or Weekly Indemnity claim payments; issue corresponding Explanation of Benefits (EOB) via e-mail to an address provided by yourself (if applicable); and assign a Personal Identification Number allowing exclusive access to your EOB messages on-line through the World Wide Web.