enVia HYBRID CRITICAL ILLNESS INSURANCE PROGRAM

So that you can concentrate on what's really important - getting better.

Introducing the first Critical Illness program to offer BOTH **immediate reimbursement** for medical & life expenses PLUS a **conventional Lump Sum Benefit** after 30 or 90 days.

It is not uncommon for a CI claimant to go into debt to cover their unanticipated medical expenses while serving out the 30 or 90-day waiting period in order to receive the lump sum payment.

We don't think that's right. In response, this new program was developed to provide immediate financial relief as it includes coverage for items such as **Ambulance, Drugs, Hospital Accommodation & Parking Fees, Private Duty Nursing,** and **Childcare** while the covered person is going for treatments. Should the covered person not survive the waiting period to qualify for the lump sum benefit, the medical expenses incurred would still be reimbursed.

Key Features:

- **Individual program** available to both Canadian residents and those on expatriate assignment.
- Unique **$25K + $25K** or **$50K + $50K matching hybrid benefit**.
- **Simple underwriting** consists of approval of a short-form health statement.
- **Designed to cover the key critical illness** conditions that make up over 85% of the total CI claims in Canada today.
- Many Group CI programs include from 3 to 30+ conditions, most of which are not "life threatening". The enVia Program covers the eight **conditions that most Canadians are concerned with** as potentially impacting on their lives.

The **enVia Individual Hybrid Critical Illness Insurance Program provides up to $100,000 coverage** for 8 covered conditions! It has been designed to provide a **combination of immediate reimbursement** of eligible medical expenses incurred as the result of a newly diagnosed covered critical illness; **followed by a lump sum payment** (after meeting the survival requirements of 30 days, except for cancer where it is 90 days). Pre-existing conditions are excluded.

Eligibility:

The coverage is available on an individual basis (subject to approval of a short-form health statement) up to an entry age of 60 for non-smokers, and age 50 for smokers. Coverage is also available to a participant's spouse, and ceases at age 70. Group quotes are available to groups of 10 or more

Covered Critical Illness Conditions:

Alzheimer's Disease
Benign Brain Tumour
Cancer
Coronary Artery By-pass Surgery
Heart Attack
Major Organ Failure Requiring Transplant
Parkinson's Disease
Stroke

LEARN MORE:

www.envia.ca **info@envia.ca**

enVia Critical Illness

Combined Medical Expense & Lump Sum Benefit

Monthly Premium Costs:

Age at Enrolment (or renewal on Jan. 1st)	Non-Smoker $25,000 / $25,000	Smoker $25,000 / $25,000	Non-Smoker $50,000 / $50,000	Smoker $50,000 / $50,000
< 25	$9.03	$13.54	$18.06	$27.08
26 - 30	$11.77	$23.54	$23.54	$47.09
31 - 35	$15.35	$30.71	$30.71	$61.42
36 - 40	$19.22	$38.43	$38.43	$76.87
41 - 45	$25.74	$51.48	$51.48	$102.95
46 - 50	$36.27	$90.68	$72.54	$181.36
51 - 55	$51.67	$129.17*	$103.34	$258.35*
56 - 60	$66.56	$179.72*	$133.12	$359.43*
61 - 65*	$102.90	$277.82*	$205.80	$555.65*
66 - 69*	$145.32	$392.38*	$290.65	$784.75*

* Renewal Rates Only

Non-Smoker rates are applicable to persons who have not smoked cigarettes, Cigarillos, Pipe tobacco, Marijuana, Herbal Tobacco, Electronic cigarettes or have used snuff, Chewing tobacco or any form of nicotine products (patch, gum) within the last 12 months.

A. Medical Expense Reimbursement:

The Program provides reimbursement at 100% of eligible expenses to a **maximum of $25,000 or $50,000 CDN per covered illness** (an amount equal to the principal sum selected). Coverage is in addition to any group or individual health program that the insured is covered under and includes:

- **Surgical and Medical Services** directly related to the covered Critical Illness
- **Semi-Private Hospital accommodation** and other inpatient services and supplies
- **Diagnostic Procedures** – Medically necessary diagnostic procedures related to a covered condition
- **Medical and Surgical Referrals** – when required
- **Other Medically Necessary Services, Supplies and Prescription Drugs** related to a covered Critical Illness, including:
  1. **Private duty nursing** at home;
  2. **Ambulance**;
  3. **Hospital Parking Fees** (for policyholder or immediate family members only while undergoing treatment); and
  4. **Child Daycare Expenses** for dependent children < 14.

B. Lump Sum Benefit:

The **$25,000 or $50,000 CDN lump sum benefit** matches your chosen Medical Expense Reimbursement, and is payable after the qualifying survival period of 30 or 90 days has been confirmed. **The Lump Sum Benefit can be used in any manner by the claimant.**

Option A: 25/25

$25,000 Lump Sum Benefit
(plus $25,000 Medical Expense Reimbursement)

Option B: 50/50

$50,000 Lump Sum Benefit
(plus $50,000 Medical Expense Reimbursement)

MACLAGAN INC.
19 Peony Street, Markham, Ontario L6B 1K9
905-554-0875 phone | **1-877-755-9670** toll-free | **416-453-9430** cell
info@envia.ca | **www.envia.ca**

Critical Illness Insurance Application Form

Part A: General Information

Applicant: ◯ **Smoker** ◯ **Non-Smoker** Non-Smoker: Applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the last 12 months before the Effective Date of their policy.

Last Name _____ First Name _____ Gender M/F _____ Date of Birth _____

Address _____ City _____ Province/State _____ Postal Code: _____ Country _____

Email _____ Phone (Res.) _____ Phone (Bus.)_____

Employer / Company _____ Date Coverage to become Effective _____

Spouse (optional): ◯ **Smoker** ◯ **Non-Smoker** Non-Smoker: Applicants who have not smoked cigarettes, cigars, cigarillos, pipe, marijuana, or used snuff, chewing tobacco or nicotine products (patch, gum, etc.) within the last 12 months before the Effective Date of their policy.

Last Name _____ First Name _____ Gender M/F _____ Date of Birth _____

Address _____ City _____ Province/State _____ Postal Code: _____ Country _____

Email _____ Phone (Res.) _____ Phone (Bus.)_____

Employer / Company _____ Date Coverage to become Effective _____

Part B: Benefit Selection and Cost

Age at Enrolment	Non-Smoker $25,000 + $25,000	Smoker $25,000 + $25,000	Non-Smoker $50,000 + $50,000	Smoker $50,000 + $50,000
< 25	$9.03	$13.54	$18.06	$27.08
26 - 30	$11.77	$23.54	$23.54	$47.09
31 - 35	$15.35	$30.71	$30.71	$61.42
36 - 40	$19.22	$38.43	$38.43	$76.87
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** Renewal Rates Only

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Applicant:

I apply for the following amount of coverage: ◯ Option 1 - $25K + $25K ◯ Option 2 - $50K + $50K at a monthly rate of $_____(a) (copy rate from table above)

Spouse (optional):

I apply for the following amount of coverage: ◯ Option 1 - $25K + $25K ◯ Option 2 - $50K + $50K at a monthly rate of $_____(b) (copy rate from table above)

Part C: Payment Options

I / We hereby authorize Global Benefit Advisors to collect the required monthly premium indicated on line (c) below using:

◯ Option 1 - Cheque attached

◯ Option 2 - INTERAC e-Transfer®

◯ Option 3 - Pre-Authorized Debit Add lines (a) + (b) above to calculate your monthly premium $_____(c)

Applicant Signature: _____ Spousal Signature (if applicable): _____

NOTE: Global Benefits Advisors may terminate coverage or change the method of payment to another qualifying method should your payment be refused for any reason and the financial institution shall in no way be held liable should such an event occur. A $25.00 fee will be charged for all NSF (Non-Sufficient Funds) Transactions. If you have any questions concerning your payment, contact us as 403-457-4111, www.gbainsure.com or write to us at Global Benefits Advisors, 21 Riverside Circle SE, Calgary AB, T2C 3X9.

GBA Medical Declaration

Section 1: General Information

SURNAME	GIVEN NAME	INITIAL

DATE OF BIRTH (MM/DD/YYYY)	NAME OF EMPLOYER (If applicable)

Section 2: Health Declaration (Please answer each section below, incomplete forms will be returned)

Have you or any of your dependents ever been diagnosed with or received medical treatment for any of the following? For each "YES" answer to any of the questions below, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on reverse.

1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	**APPLICANT**	**SPOUSE**	**DEPENDENTS**
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Diabetes, Colitis or Crohn's?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fybromyalgia?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Chronic Headaches, Migraines or recurrent infections?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Skin Disorder (including Acne)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) Alcoholism or Drug Abuse/Dependency?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) Other Condition/Disease/Disorder/Injury – Please specify:_____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you ever had or been told you had AIDS, ARC, immune system abnormality or test results indicating exposure to the AIDS virus or any sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the last 5 years have you consulted a doctor or any other health care practitioner for ECGs, blood tests, Xrays, or any other test, or had any surgery or received any treatment in a hospital, or has any such treatment or surgery been recommended to you?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you currently taking or have you been prescribed any prescription medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you ever made an application for life, disability or health insurance, where the application was declined, modified, offered on special terms, or is currently pending with another insurer?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the last 2 years have you engaged in, or do you expect to engage in, any high risk activities such as scuba diving, sky diving, motor racing, rock climbing, piloting aircraft, or bungee jumping?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

GBA Medical Declaration

Section 3: Details for questions answered "Yes" in Section 2

Please provide details for any question answered "Yes" in section 2 of this questionnaire.							
Question #	Name of Applicant, Spouse, or Dependent	Illness / Condition	Date of Onset (d/m/y)	Frequency of Episodes	Date of Recovery	Medication / Treatment	Daily Dosage

Authorizations and Declarations
I authorize:

Global Benefits Advisors, any health care provider, my plan administrator, other insurance companies or reinsurance companies, the Medical Information Bureau, administrators of government benefits or other benefit programs, other organization, or service providers working with Global Benefits Advisors to exchange personal information, when necessary to determine my insurability and to administer the benefits plan.

I certify or confirm that:

- I have retained a copy of this application.
- A photocopy or an electronic copy of this authorization is as valid as the original.

The statements and answers on this form will be used to determine your insurability and to provide benefits under the plan. Any changes in the accuracy of the statements and answers on the form between the date this form is signed and the date Global Benefits Advisors makes a decision must be reported to Global Benefits Advisors. I understand that failure to do so could result in coverage being voided.

I declare that to the best of my knowledge, all of the above answers to the questions are complete and true. I understand that if any answer is incomplete or false, any coverage granted may be voided. I understand that I may be refused for coverage for all or part of any benefit if, in the opinion of Global Benefits Advisors or it underwriters, I am not insurable for all or part of that benefit.

Plan Member Signature	**Date** (D/M/Y)
Please forward completed forms to: Global Benefits Advisors Ltd 21 Riverside Circle SE. Calgary, Alberta, Canada T2C 3X9	**Global Benefits Advisors Ltd. USE ONLY** **Policy No.**

Protecting your Privacy

At Global Benefits Advisors Ltd, we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that is kept in the offices of Global Benefits Advisors or the offices of an organization authorized by us (located within or outside of Canada). We limit access to personal information in your file to Global Benefits Advisors staff or persons authorized by Global Benefits Advisors who require it to perform their duties, to persons to whom you have granted access and to persons authorized by law. We use the personal information to determine your insurability and to administer the benefits plan.