enVia

INCOME PROTECTION

Comprehensive Disability Insurance that pays monthly income benefits and lump-sum payments in the event of injury or illness.

Protect everything you've worked so hard for.

NOW THAT'S PEACE OF MIND.

Identify your needs. The primary concern of most people is their ability to meet their ongoing financial obligations in the event of temporary or long term disability. **How would you or you and your family survive financially if you became disabled and unable to work?**

Choose your coverage. The **enVia Income Protection Program is modular in design**, allowing you to purchase the entire program as one all-encompassing "umbrella", or any of the individual component benefits based on your needs.

Relax! The **enVia Income Protection Program** offers 24/7 coverage in the event of injury or illness with a unique combination of monthly income benefits and lump-sum payments.

WHY YOU NEED IT:

Disability Insurance should be the number one priority in terms of benefit protection because, unless a person is very wealthy, one cannot normally self-insure the ability to work.

Although many people think first about dental insurance, for example, because of an impending expense for major dental work, a much sounder approach is to have Disability Insurance in place first, and if necessary, finance over time any infrequent major expense. **It just makes sense to protect the asset that's most valuable** - your ability to earn an income makes possible all the other elements of your life.

HELPING YOU MAKE THE RIGHT CHOICES.

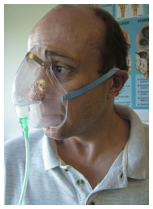
MODULAR DESIGN PROVIDES REAL-WORLD, NEEDS-RELATED COVERAGE OPTIONS:

1. Temporary Total Disability (TTD)

A weekly income TTD benefit of up to 70% of weekly earnings for a maximum duration of 24 months (2 years), following a 30 or 90 day waiting period. The benefit payable is reduced by any disability benefits for which you may be eligible from the C/QPP or E.I. Provides protection for disabilities resulting from an injury or illness. **Maximum benefit of $2,308 per week ($10,000 per month).**

2. Permanent Total Disability (PTD)

Provides a **lump sum, tax-free benefit up to 5 X gross annual earnings (up to a maximum of $2,000,000)** in the event that you are "permanently and totally" disabled after 25 or 27 months, and unable to "engage in any occupation or employment for which you are fitted by reason of education, training or experience for the remainder of your life". Once PTD is determined, the lump sum payment is made and no further ongoing proof of disability is required as is the case under a traditional plan.



3. Accidental Death & Dismemberment (AD&D)

A lump sum, tax-free benefit of up to $500,000 payable in the event of accidental death or dismemberment, paralysis, loss of use, loss of vision, hearing, etc. **This benefit is payable in addition to any benefits payable under the TTD and PTD benefits.** Provides 24 hour, 365 days per year coverage, available in units of $50,000 up to a maximum of $500,000.

WHAT WOULD YOU DO?

It's by far your most valuable asset: **your ability to work and earn an income.**

Yet more than half of working Canadians have not purchased disability insurance to protect this asset, perhaps simply hoping nothing will ever happen to them.

While none of us wish to contemplate misfortune, the truth is that disability has no respect for age, gender, occupation or position when it strikes unexpectedly through sudden illness or accident.

AN AFFORDABLE SOLUTION:

The **enVia Income Protection Program** can help you meet your protection needs at a reasonable & competitive cost, while providing you and your loved ones with comprehensive protection against loss of income due to illness injury or death.

NO MEDICALS REQUIRED!

No medical examinations are required for approval. Instead, satisfactory Health Evidence is required in the form of a Personal Health Declaration. All such information is confidential, shared only among the Program Administrator and Insurers/Service Providers. (Note: Final premium rates for TTD benefit coverage are subject to adjustment based on the health conditions disclosed.)

HOW TO APPLY:
If you are Full-Time & under Age 70.

Complete the **Application Form and Health Declaration**, indicating your benefit choices and providing the personal information requested. Please answer the Health Questions fully and accurately, and provide explanatory details as required. Sign the forms and return to the address indicated. Monthly premium payments are made via pre-authorized withdrawal from your bank account.

POLICY DEFINITIONS

Definition of Total Disability: The inability to perform the the principal duties of any occupation in relation to your education, skills, training and experience."

"Permanent Total Disability" means the the Insured Person's complete inability, after 2 years of continuous total disability to engage in any occupation or employment for which the Insured Person is fitted by reason of education, training or experience for the remainder of his life.

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INCOME PROTECTION

YOUR ABILITY TO EARN AN INCOME MAKES POSSIBLE ALL THE OTHER ELEMENTS OF YOUR LIFE.

True security:

Let's be frank. We sell a lot of Health & Dental Benefits coverage and Life Insurance because they're important elements of your overall financial security. But if we could recommend just one kind of insurance that would provide true security for most people, it would be Disability Insurance - it's the only way to really protect the life you're working so hard to build for yourself and your family. Think about it. If your income was suddenly ended by accident or illness, what would happen next?

Surprisingly affordable:

You might think that insuring your ability to meet your financial obligations in the event of disability would be expensive, but it's actually quite affordable. And when you consider what could happen without it, it's downright cheap. Take a look at the rates in the Application Form, and you'll see that we can provide you and your loved ones with comprehensive coverage at a reasonable cost.

Experienced Service Providers and Trusted Insurers:

Having coverage is one thing, but having the right people on the other end of the line to handle your inquiries and claims promptly and professionally is just as important. That's why the **enVia Income Protection Program** is administered by **Special Risk Insurance Managers Ltd.**, and underwritten by **Lloyd's (Certain Underwriters)**.

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

Toll-free: 1-877-755-9670
Fax: 705-721-0352
E-mail: info@envia.ca

enVia Disability / Income Protection Program Application Form

Please submit this Application, and the Personal Health Declaration. For more information or assistance in completing this application, or to request additional applications & health statements, please contact us.

Section 1: General Information

Effective Date of Coverage Requested: _____

YOUR NAME (LAST NAME / FIRST NAME / INITIAL)			MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ COMMON-LAW ☐ OTHER _____
DATE OF BIRTH (DD/MM/YYYY)	SEX ☐ MALE ☐ FEMALE	LANGUAGE ☐ ENGLISH ☐ FRENCH	PRIMARY OCCUPATION / ANNUAL EARNINGS
HOME ADDRESS	CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE	WORKPLACE TELEPHONE	FAX	
EMAIL ADDRESS	YOUR BUSINESS TYPE OR EMPLOYMENT STATUS ◯ OWNER/SELF-EMPLOYED ◯ EMPLOYEE ◯ CONTRACTOR ◯ TEMP		
YOUR BUSINESS OPERATING NAME	YOUR 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 - please indicate your requested coverage.

(choose any combination or all coverage options)

◯ **Optional TTD** ◯ **Optional PTD** ◯ **Optional AD&D**

Section 3: Occupational Class & Rate Determination

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. In some cases, a separate application form may be required.

Determine your Occupational Class: Insurers base their rates for some coverage in part on the nature of the work being performed as part of your regular duties. Use the table below to determine your Occupational Class for TTD, PTD and AD&D Coverage. Please contact us if it's not clear what category matches your particular job.

◯ **Class 1**	All Administrative Office Staff, Office based Managers, Accountants, Sales Staff, IT Staff, Graphic Designers, Real Estate Agents, Lawyers, Retail Sales Staff.
◯ **Class 2**	All on-site Managers and Superintendents at Mining & similar Operations, Lab Technicians.
◯ **Class 3**	Nurse, Physiotherapist, Massage Therapist, Personal Support Worker, Nannies, Hospital Cleaning Staff, Light Industrial Workers.
◯ **Class 4**	All on-site manual workers not exposed to unusual accident risks such as Foreman, Electricians, Finish Carpenters, Plumbers, Cooks, Courier Drivers, Short Haul Truck Drivers, Auto Body Painters, Daycare Worker, Flooring Installers, Cement Layers & Finishers, Painters, and Other Skilled Trades.
◯ **Class 5**	All on-site heavy manual workers exposed to considerable accident risks, such as Rough Carpenters, Industrial Mechanics, Auto Mechanics, Steamfitters, Farmer, Movers, Restaurant Server, Long Haul Truck Driver, Landscape Workers, and Bricklayers.

☐ a) Temporary Total Disability Benefits (TTD):

Following a 30 or 90 day waiting period, benefit payable is 70% of weekly earnings to a maximum of $2,308 week.
Note: Final premium rates for benefit coverage are subject to adjustment based on the health conditions disclosed.

◯ **30 Day Elimination** ◯ **90 Day Elimination**

Occupational Class (from table above)	Rate per $10 of Weekly Benefit per month		Monthly Cost per $500 of Weekly Benefit		Monthly Cost per $750 of weekly benefit		Monthly Cost per $1,000 of weekly benefit		Monthly Cost per $1,500 of weekly benefit	
Elimination Period	**30 Day**	**90 Day**	**30 Day**	**90 Day**	**30 Day**	**90 Day**	**30 Day**	**90 Day**	**30 Day**	**90 Day**
Class 1	$0.527	$0.448	$26.35	$22.40	$39.53	$33.60	$52.70	$44.80	$79.05	$67.20
Class 2	$0.561	$0.477	$28.05	$23.85	$42.08	$35.78	$56.10	$47.70	$84.15	$71.55
Class 3	$0.706	$0.600	$35.30	$30.00	$52.95	$45.00	$70.60	$60.00	$105.90	$90.00
Class 4	$0.762	$0.648	$38.10	$32.40	$57.15	$48.60	$76.20	$64.80	$114.30	$97.20
Class 5	$0.897	$0.762	$44.85	$38.10	$67.28	$57.15	$89.70	$76.20	$134.55	$114.30

Weekly Earnings $_____ X 70% = Weekly Benefit $_____ ÷ 10 = _____ X Class Rate per $10 _____ = **Monthly Cost $_____(a)**

(MAXIMUM $2,308)

☐ b) Permanent Total Disability Benefits (PTD):

Provides a benefit of up to 5X annual earnings after 25 or 27 months

Occupational Class (from table above)	Monthly Rate / $1,000	Monthly Premium / $50,000	Monthly Premium / $250,000	Monthly Premium / $500,000
Class 1	$0.040	$2.00	$10.00	$20.00
Class 2	$0.056	$2.80	$14.00	$28.00
Class 3	$0.079	$3.95	$19.75	$39.50
Class 4	$0.110	$5.50	$27.50	$55.00
Class 5	$0.154	$7.70	$38.50	$77.00

Annual Earnings $_____ X 5 = PTD Benefit $_____ ÷ 1000 = _____ X Class Rate per $1,000 _____ = **Monthly Cost $_____(b)**

(MAXIMUM $2,000,000)

☐ **c) Accidental Death & Dismemberment:** No Health Statement required. Available in multiples of $50,000 to a maximum of $500,000.

Occupational Class (from table above)	Monthly Rate / $1,000	Monthly Premium / $50,000	Monthly Premium / $250,000	Monthly Premium / $500,000 (maximum benefit)
Class 1	$0.09	$4.50	$22.50	$45.00
Class 2	$0.10	$5.00	$25.00	$50.00
Class 3	$0.12	$6.00	$30.00	$60.00
Class 4	$0.15	$7.50	$37.50	$75.00
Class 5	$0.20	$10.00	$50.00	$100.00

Coverage required $_____ ÷ 1000 = _____ X Class Rate per $1,000 _____ = **Monthly Cost $_____(c)**
(MAXIMUM $500,000)

Beneficiary Designation: (applies to the Optional AD&D from Lloyd's of London, if applicable)

○ 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_____

Section 4: Calculate your Monthly Cost:

1. Disability/Income Protection Benefits Cost:
Total the amounts from lines (a) through (c) to determine your Optional Disability/Income Protection Benefits cost.
Note: Final premium rates for TTD benefit coverage are subject to adjustment based on the health conditions disclosed.

IMPORTANT:
You must also complete the attached enVia MDM PAC Authorization Form to authorize monthly premium payments via electronic funds transfer.

$_____**(a)**

$_____**(b)**

$_____**(c)**

$_____
Total Monthly Benefits Cost

Section 5: Declaration & Authorization

I acknowledge that Personal Information collected with this Application for Insurance is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the insurance protection that is afforded to Applicants under this plan.

I understand that coverage commences only after the Plan Administrator confirms our acceptance in writing.

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.

Signed at: _____, _____ this _____ day of _____, _____ Applicant's Signature _____
CITY / TOWN PROVINCE DATE MONTH YEAR

Mail, Fax or Scan & Email your completed application to:

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

enVia
INCOME PROTECTION

Toll-free: 1-877-755-9670
Fax: 705-721-0352
E-mail: info@envia.ca

enVia BUSINESS SOLUTIONS

Personal Health Declaration

Please complete this Personal Health Declaration accurately and in full. In particular, if you answer "YES" to any of the medical questions below, please provide details on reverse.

Section 1: Applicant Information

APPLICANT NAME	DATE OF BIRTH (DAY / MONTH / YEAR)	APPLICANT'S HEIGHT	APPLICANT'S WEIGHT
		_____ ☐ ft/in or ☐ cm	_____ ☐ lbs or ☐ kg

NAME OF APPLICANT'S EMPLOYER	DATE EMPLOYED (DAY / MONTH / YEAR)	CERTIFICATE OR PAYROLL NUMBER (OFFICE USE ONLY)

OCCUPATION	NORMAL NUMBER OF HOURS WORKED PER WEEK	DIVISION / CLASS (OFFICE USE ONLY)

Section 2: Health Declaration

Have you 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.

	APPLICANT
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:	
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	☐ YES ☐ NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	☐ YES ☐ NO
c) Diabetes, Colitis or Crohn's?	☐ YES ☐ NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	☐ YES ☐ NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fybromyalgia?	☐ YES ☐ NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	☐ YES ☐ NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	☐ YES ☐ NO
h) Chronic Headaches, Migraines or recurrent infections?	☐ YES ☐ NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	☐ YES ☐ NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	☐ YES ☐ NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	☐ YES ☐ NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	☐ YES ☐ NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	☐ YES ☐ NO
n) Skin Disorder (including Acne)?	☐ YES ☐ NO
o) Alcoholism or Drug Abuse/Dependency?	☐ YES ☐ NO
p) Other Condition/Disease/Disorder/Injury - Please specify:_____	☐ 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
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
4. Are you currently taking or have you been prescribed any prescription medications?	☐ 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
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
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
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	☐ YES ☐ NO
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	☐ YES ☐ NO

Section 3: Travel Declaration

Do you travel outside of Canada for business or volunteer work? ☐ YES ☐ NO

If YES, outline where you travel to and how frequently:

Location: _____ Frequency: _____ Duration of Trip(s): _____

Section 4: Your Physician

Full name and address of your regular attending physician: If you do NOT have a regular physician, provide this information regarding any medical or walk-in clinic that you attend, or the last doctor or clinic where you were seen for any reason. **If the answer is "none", state "none".**

NAME OF APPLICANT'S PHYSICIAN	ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT
NAME OF SPOUSE'S PHYSICIAN	ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT

For each "YES" answer to any of the questions in Section 2, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable.

Section 5: Details for questions answered "YES" in Section 2

Please provide details for any question answered "YES" on reverse. If additional space is required, please attach a separate sheet.

Question #	Name of Applicant	Illness / Condition	Date of onset	Frequency of episodes	Date of recovery	Medication / Treatment	Daily Dosage	Approximate monthly cost

Section 6: Declaration & Authorization

I understand that, to be eligible for the insurance for which I am applying, I must at all times be covered under my provincial government health plan and be a Canadian resident.

I agree that the statements and answers in this Declaration, on any medical examination and in any written statements or answers furnished as evidence of my insurability shall form the basis of any insurance granted under the terms of the policy issued me. I understand that the Insurers or their service providers reserve the right to verify the answers provided to the questions contained in this Personal Health Declaration at the time of any claim for benefits under the policy issued to me. I declare that all statements and answers recorded in this Declaration are as given by me and are true and complete.

I hereby authorize the Insurer or its service providers, for underwriting and administration of insurance and claims paying purposes only:

(a) To gather only that information necessary for the objective of the Disability Benefits file from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the objective of this file;

(b) To disclose only the necessary personal information it has relating to me to these same persons and organizations, or as required by law;

(c) To request a personal investigation report relating to me.

A photocopy of this Authorization shall be as valid as the original.

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

Applicant's Signature_____

This authorization is valid for the period required to achieve the ends for which it was requested.

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

Toll-free: 1-877-755-9670
Fax: 705-721-0352
E-mail: info@envia.ca

MDM Insurance Services Inc.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

Benefits Program Invoice Payment

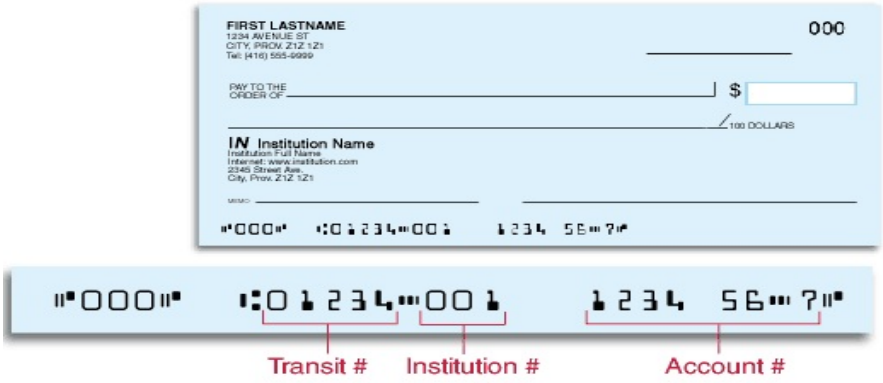
Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

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)