Application and Enrollment

CostPlus Corporation
P.O. Box 28115 Oakridge
London, ON N6H 5R2
Telephone: (519) 204-2132

email address: mailroom@costplus-benefits.com
virtual office: http://www.costplus-benefits.com

between _____

insert the complete and formal Legal Name of the Employer
in the capacity of **Sponsors**, hereinafter referred to as the **Employer**

and the **CostPlus Corporation**
in the capacity of **Trustees**, hereinafter referred to as **CostPlus**

The CostPlus Program is provided according to the following conditions:

Administration Fees

The **Employer** hereby agrees to provide **CostPlus** with an **Annual Program Fee** and funds sufficient to **fully indemnify eligible Expenses** incurred by the **eligible Employees**, or their **eligible Dependents**, and the **applicable Processing Fees as a percent of Claims** submitted and **Premium** and **Sales Taxes**. The **Employer guarantees to indemnify CostPlus** for any time and expenses incurred in **collection of funds which are in default by the Employer.**

Fees	**Annual Program Fee**	**$100.00**	**plus HST**
	Claims Processing Fee	**10.00%**	**plus PST and Premium Tax**
Taxes	**Ontario Premium Tax is**	**2.00%**	**currently**
	Ontario Sales Tax is	**8.00%**	**currently**
	HST	**13.00%**	**currently**

Claims Indemnification

CostPlus hereby agrees to provide funds sufficient to **discharge** the actual **eligible Expenses** incurred by the enrolled **Employees**, or **eligible Dependents**, by payment of such applicable funds **directly to the Health Care Provider or Dental Care Practitioner**, or **reimbursement to the enrolled Employee**, if such **eligible Expenses** have already been paid by the Employee, and an **original of Receipt of Payment** is provided to **CostPlus** as evidence of prior payment.

Enrollment Requirement

Enrollment of Employees shall be at the **sole discretion of the Employer**, and the **enrolled Employees** shall be eligible for indemnification of Health, Vision, Dental Care and Counselling Expenses incurred by them, or incurred by their **Eligible Dependents**, in accordance with the **CostPlus** eligible provided expenses, until **due Notice** is given **by the Employer to CostPlus** that the enrollment of the specified Employee is **Terminated** as of the date given in such notice.

Indemnification Levels

Indemnification shall be made on behalf of **enrolled Employees** and their **eligible Dependents**, allowable under **Federal and Provincial Legislation**, and **not in duplication of other benefits. Indemnification** shall be made on **Claims Authorized by the Employer**, who may **enhance** or

limit Claims by **Annual Deductibles**, **Reimbursement Percentages** or **Annual Maximums**.
Processing of Claims

Any and all monetary **transactions** required **under this Agreement** shall be **processed** by the **Employer and by CostPlus** within **48 hours** of receipt of all required documentation.

Additional Documents

The Agreement, Employee Enrollment, Program Provisions and Coverage Descriptions shall form part of the Agreement, unless Amended by the **consent of the Employer and CostPlus**.

Agreement Effective

The Agreement is **Effective on the first day of the month** following the **Employers date of Signature** and the **CostPlus date of Signature**, and each **subsequent anniversary renewal**.

Agreement Amendments

The Agreement may be **Amended by CostPlus** on **thirty days of Notice to the Employer**, and such **Notice** may be delivered or transmitted by **Letter, E-mail or telephone Facsimile**.

Agreement Termination

The Agreement may be **Terminated** by the **Employer** or **CostPlus** on **thirty days** written **Notice**, **subject to completion of any and all transactions started prior to Termination**.

Legislative Requirements

It is the **obligation of the Employer** to ensure that **Claims for eligible Employees** and their **eligible Dependents** and applicable **Administration Fees** and **Federal and Provincial Taxes** are **submitted to the CostPlus Corporation**, and that **Enrollment of Employees** and **Claims submitted** conform to requirements of the **Income Tax Act** and any **additional Legislation.**

for the **Employer** _____

signature of the business or corporate **Signing Officer**

_____

name of the business or corporate **Signing Officer**

signed on **Month, Day, Year** _____

Please Complete Information on Next Page

Employer Information

Business Name _____
Administrator _____
Business Address _____
City and Province _____
Postal Code _____

Telephone Number _____ **Facsimile Number** _____
Toll Free Number _____ **E-mail Address** _____

Business Type **[ ] Retail or Wholesale [ ] Manufacturing or Transportation**
[ ] Professional Services [ ] Other (specify below)

_____

Consultant Information

Consultant _____
Business Name _____
Business Address _____
City and Province _____
Postal Code _____

Telephone Number _____ **Facsimile Number** _____
Toll Free Number _____ **E-mail Address** _____

Consultant Type **[ ] Insurance Consultant [ ] Financial Consultant**
[ ] Legal Consultant [ ] Other (specify below)
_____

Purpose of Plan

[ ] to provide additional Executive Compensation
[ ] to enhance prepaid Health and/or Dental Care
*** [ ] to replace prepaid Health and/or Dental Care**

*** if CostPlus will replace existing Health and/or Dental Care, please ensure that notification is given to the Agent or Insurer.**

Please Complete Information on Next Page

Class Descriptions
use additional page for another Class
_____ Number of Participants _____

Eligibility
[ ] Starting the first day of employment
[ ] Starting the first of the month following ____ months of employment
[ ] Starting the first day after having completed ____ months of employment

Employees of the Employer,
in the specified Class of Employees.
including the following if selected:
[ ] including part-time or full-time Employees.
[ ] including termination settlement for Employees.
[ ] including continuation of benefits for retired Employees.
[ ] including temporary continuation for laid-off Employees.

Spouse or Common-Law Spouse of the Employee, and
Children of the Employee, Spouse or Common-Law Spouse.
including the following if selected:
[ ] Grandchildren of the Employee or Spouse.
[ ] Parents, Grandparents, Brothers, Sisters, Uncles, Aunts, and Nieces or Nephews, residing in Canada and related by blood, marriage or adoption, to the Employee or Spouse.

Benefits Selected
[ ] Dental Care - Basic Services
[ ] Dental Care - Endodontics and Periodontic Services
[ ] Dental Care - Major Restorative Services
[ ] Dental Care - Orthodontic Services
[ ] Health Care - including Drugs
[ ] Vision Care Services
[ ] Counselling Services
[ ] Survivor Benefits

Limitations
[ ] Percent of Claims Reimbursed _____ percent

Maximums
[ ] Combined Calendar Year Maximums: Single _____ amount
Family _____ amount
[ ] Maximums are at the discretion of the Employer (if left blank above)
[ ] Maximums are prorated for months remaining in first Calendar Year

Completion Instructions
Retain a copy of the Application and Enrollment Forms, and Submit Originals
Include a Business Cheque, payable to CostPlus Corporation, in the Amount of $100.00 for the Annual Program Fee (total for all Classes) plus $13 for HST