



enVia

INCOME PROTECTION



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



Employee Benefit Consultants / Insurance Brokers

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 66.7% of weekly earnings for a maximum duration of 24 months, following a 30 day waiting period. The benefit payable is not reduced by any disability benefits for which you may be eligible from the C/QPP or E.I. The benefit may be purchased to provide protection for disabilities resulting from an accident only, or as the result of an injury or illness. Maximum benefit of \$1,500 per week.

2. Permanent Total Disability (PTD)

Provides a lump sum, tax-free benefit equal to 5 X gross annual earnings (up to a maximum of \$500,000) in the event that you are “permanently and totally” disabled after 25 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.

4. Limited Pay Life Insurance (20 Years)

Peace of mind for you and your dependents. Participants may purchase optional Life Insurance for themselves and/or their spouse in units of \$25,000 or \$50,000, subject to approval of an application by the insurer. Coverage continues for life and provides post-retirement protection with Cash Values.



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.

HOW TO APPLY:

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. Your monthly premium payments are made via pre-authorized withdrawal from your bank account.



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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 Norfolk Mobility Benefits (Calgary), and underwritten by Lloyd's of London (Certain Underwriters).



Employee Benefit Consultants / Insurance Brokers

19 Peony Street, Markham, Ontario L6B 1K9 905.554-0875 p 905.294.2235 f www.maclagan.ca



enVia Disability / Income Protection Program Application Form



Please submit this Application, and, if required, the Personal Health Declaration with a cheque marked "VOID". For more information or assistance in completing this application, or to request additional applications & health statements, please contact **MACLAGAN INC.** at **905-554-0875**.

Section 1: General Information **Effective Date of Coverage Requested:** _____

YOUR NAME LAST NAME: _____ FIRST NAME: _____ INITIAL: _____			MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> OTHER _____		
DATE OF BIRTH (DD/MM/YYYY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	LANGUAGE <input type="checkbox"/> ENGLISH <input type="checkbox"/> FRENCH	PRIMARY OCCUPATION		ANNUAL EARNINGS
HOME ADDRESS		CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE		WORKPLACE TELEPHONE	FAX		
EMAIL ADDRESS		YOUR BUSINESS TYPE OR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SELF-EMPLOYED (INCORPORATED) <input type="checkbox"/> SELF-EMPLOYED (SOLE PROPRIETOR)			
YOUR BUSINESS OPERATING NAME		YOUR BUSINESS ADDRESS		CITY	PROVINCE
YOUR AGENT / BROKER'S NAME (IF APPLICABLE) MACLAGAN INC.		AGENT / BROKER'S TELEPHONE: 905-554-0875		AGENT / BROKER'S E-MAIL ADDRESS: esmaclagan@rogers.com	
AGENT / BROKER'S ADDRESS: 19 PEONY STREET		CITY MARKHAM	PROVINCE ONTARIO	POSTAL CODE L6B 1K9	

Section 2: Coverage Selection - please indicate your requested coverage.

Optional Disability / Income Protection (TTD and/or PTD)

 Optional Life

 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 Life, TTD, PTD and AD&D Coverage. Please contact us if it's not clear what category matches your particular job.

<input type="radio"/> Class 1	All Administrative Office Staff, Office based Managers, Accountants, Sales Staff, IT Staff, Graphic Designers, Real Estate Agents, Lawyers, Retail Sales Staff.
<input type="radio"/> Class 2	All on-site Managers and Superintendents at Mining & similar Operations, Lab Technicians.
<input type="radio"/> Class 3	Nurse, Physiotherapist, Massage Therapist, Personal Support Worker, Nannies, Hospital Cleaning Staff, Light Industrial Workers.
<input type="radio"/> 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.
<input type="radio"/> 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 day waiting period, benefit payable is 66.67% of weekly earnings to a maximum of \$1,500 week.

Occupational Class (from table above)	Rate per \$10 of 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 (maximum)
Class 1	\$0.458	\$22.90	\$34.35	\$45.80	\$68.70
Class 2	\$0.488	\$24.40	\$36.60	\$48.80	\$73.20
Class 3	\$0.614	\$30.70	\$46.05	\$61.40	\$92.10
Class 4	\$0.663	\$33.15	\$49.73	\$66.30	\$99.45
Class 5	\$0.780	\$39.00	\$58.50	\$78.00	\$117.00

Weekly Earnings \$ _____ X 66.67% = Weekly Benefit \$ _____ ÷ 10 = _____ X Class Rate per \$10 _____ = **Monthly Cost \$ _____ (a)**
(MAXIMUM \$1,500)

b) Permanent Total Disability Benefits (PTD): Provides a benefit of up to 5X annual earnings after 25 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 \$500,000)

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)

d) Limited Pay Permanent Life Insurance: In units of \$25,000 or \$50,000. Requires separate application and medical underwriting.

Yes, please provide me with a quotation.

e) XN Global® Preferred Care Program: Requires separate Application Form & Health Statement, but please indicate here if you will be purchasing coverage.

Yes, please provide me with a quotation.

AD&D Beneficiary Designation: (please complete this section ONLY IF APPLYING FOR AD&D COVERAGE)

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:

Disability/Income Protection Benefits Cost:

Total the amounts from lines (a) through (c) to determine your monthly Disability/Income Protection Benefits cost.

\$ _____
Total Monthly Benefits Cost

IMPORTANT:

You must also complete the attached enVia Eorse PAC Authorization Form to authorize monthly premium payments via cheque or credit card.

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 health insurance protection that is afforded to Applicants, Spouses, and Dependent Children 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 or Fax your completed application to:

enVia Benefits Program
P.O. Box 47509
946 Lawrence Ave. East
Don Mills, ON M3C 3S7



Phone: (905) 554-0875

Fax: (905) 294-2235

E-mail: info@maclagan.ca



ESORSE
CORPORATION

ESORSE CORPORATION
234 Eglinton Ave. East, Suite 502
Toronto, ON M4P 1K5
Tel: 416-483-3265 Toll-free: 1-877-637-6773



enVia
HEALTH SPENDING ACCOUNT

Request for Pre-Authorized Withdrawal

Purpose:

This form is required to establish or make changes to the pre-authorized payments required for your insurance premiums or health spending account. You can choose to make payments via withdrawals from your chequing account or charges to your credit card.

My Information:

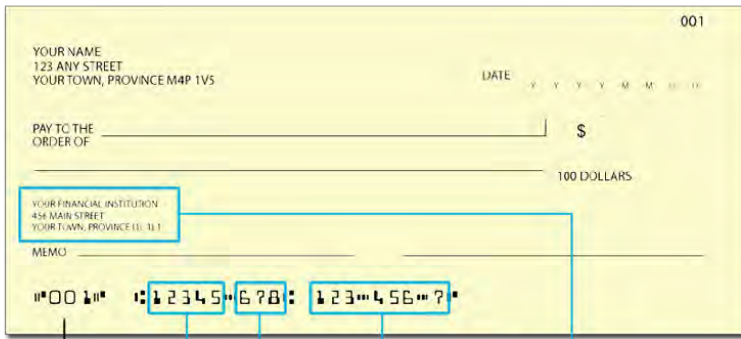
Name: Company / Employer Name:

Address: Phone:

Email: I wish to pay by: Cheque Credit Card

My Bank Information (if paying by cheque):

Using the sample cheque image as a guide, please provide the requested information to enable your monthly pre-authorized payments.



Bank Name:

Branch Address:

Bank Number:

Transit Number:

Account Number:

Cheque Number Bank Number Transit Number Account Number Bank Name & Address If you are unsure of your banking information, please attach a copy of one of your cheques marked "VOID".

My Credit Card Information (if paying by credit card):

Card Type: VISA MASTERCARD

Name as it appears on card:

Credit Card Number: Expiry Date: /

Authorization Agreement:

I hereby authorize Esorse Corporation to make automatic withdrawals for my insurance premiums and/or health spending account, either from my account at the financial institution named below, or charged to the credit card specified below.

I understand that premiums will be withdrawn on the 28th of each month for the month following.

Further, I understand that Esorse Corporation will terminate my pre-authorized payment plan if any withdrawal is reversed by my financial institution, and that this form authorizes Esorse Corporation to charge a fee for any pre-authorized payments not honored by my financial institution.

This agreement will remain in effect until Esorse Corporation receives a written notice of cancellation from me, or until I submit a preauthorized withdrawal form.

Authorized Signature: _____ Date: _____

Please complete & sign this form and fax it to: (416) 446-7371



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. If you have questions or need further assistance, please call us at (905) 554-0875

Section 1: Applicant Information

APPLICANT NAME	DATE OF BIRTH (DAY / MONTH / YEAR)	APPLICANT'S HEIGHT _____ ft/in or _____ cm	APPLICANT'S WEIGHT _____ 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:	<input type="checkbox"/> YES <input type="checkbox"/> NO
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
b) Huntington's Chorea, Amyotrophic Lateral Sclerosis, Motor Neuron Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO
d) Immune Disorders including testing for Immune Deficiency Syndrome (AIDS), Human Immune Syndrome (HIV)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
e) Arthritis, Joint Disorders, Musculoskeletal Disorders, Rheumatism, Osteoporosis, Chronic Fatigue or Fibromyalgia?	<input type="checkbox"/> YES <input type="checkbox"/> NO
f) Cancer, Tumor or Growth (except Basal Cell Carcinoma)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO
i) High Blood Pressure, High Cholesterol, Multiple Sclerosis (MS), T.I.A. (mini-stroke), Stroke, Circulatory Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
j) Digestive System Disorder, Liver Disease/Disorder including Hepatitis, Kidney disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
k) Respiratory or Allergic Disorder, including Asthma, Chronic Bronchitis, COPD, Emphysema?	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematous (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO
m) Nervous, Mental, Emotional Disorders; Alzheimer's, Parkinson's, Memory Loss or Seizure Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Are you currently taking or have you been prescribed any prescription medications?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Have you ever been treated for any other medical condition disease or disorder not mentioned above during the last 36 months?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8. Smoker/Non-Smoker status: Have you used any form of tobacco in the last 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. In the past 12 months have you experienced any symptoms that you have not sought medical attention for?	<input type="checkbox"/> YES <input type="checkbox"/> NO

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

For each "YES" answer to any of the questions above, please provide dates, illness/condition, treatment, medication/dosage, and frequency of episodes, if applicable, in the Details section on the next page.

