



enVia Income Protection / Disability Insurance 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 **416-554-0875**.

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) Life Insurance: Optional Life Insurance in units of \$10,000 to \$100,000. Coverage terminates at age 65. Please complete attached Personal Health Declaration.

Age Band	Premium rates per \$1,000 per month				
	Class 1	Class 2	Class 3	Class 4	Class 5
18-39	\$0.143	\$0.168	\$0.204	\$0.281	\$0.346
40-44	\$0.270	\$0.295	\$0.331	\$0.408	\$0.473
45-49	\$0.477	\$0.502	\$0.538	\$0.614	\$0.680
50-54	\$0.763	\$0.788	\$0.823	\$0.900	\$0.965
55-59	\$1.085	\$1.110	\$1.146	\$1.223	\$1.288
60-64	\$1.720	\$1.744	\$1.780	\$1.857	\$1.922

rate per \$1,000 per month

Coverage Required: \$ _____ ÷ 1,000 = _____ X _____ = **Monthly Cost \$** _____ (c)
 example: \$100,000 example: 100 example: \$0.295 for age 43 Class 2 example: \$29.50 per month

d) 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 \$** _____ (d)
 (MAXIMUM \$500,000)

Life and / or AD&D Beneficiary Designation: (please complete this section ONLY IF APPLYING FOR Life and/or 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:

Optional Benefits Cost:

Total the amounts from lines (a) through (d) to determine your monthly Optional Benefits cost.

IMPORTANT: Please attach a cheque marked "VOID" to enable monthly automatic withdrawals from your financial institution.

\$ _____
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 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