



MEMBER BENEFITS PROGRAM

Arranged by:



Private Health Services Plan Application – Small Group

1) CLIENT ACCOUNT INFORMATION

| | | | | |
|--------------------------------------|---|---|---|---------------------------------------|
| Legal Company Name | | | | |
| Address | | City | Province | Postal Code |
| Telephone | Fax | Email | | |
| Contact Name | | | Fiscal Year End _____ mm dd | |
| Check one: | | | | |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Sole Proprietorship (with employees) | <input type="checkbox"/> Partnership (with employees) | <input type="checkbox"/> Other: _____ |

2) BENEFIT INFORMATION

| | | |
|---|---|---|
| Number of days after Plan Year to file claims (Minimum 30 days, maximum 365 days. If not specified, claim period is 365 days) <input type="checkbox"/> Number of days _____ | Allowable Expenditure options | |
| | <input type="checkbox"/> All eligible expenditures as described in the Income Tax Act (Canada) | |
| | <input type="checkbox"/> Dental expenditures | <i>If not specified, all eligible expenditures as described under the Income Tax Act are allowable.</i> |
| <input type="checkbox"/> Vision expenditures | | |
| PHSP Effective Date _____ mm dd yyyy Eligibility effective date for all employees will commence on date noted above unless otherwise noted on Employee Enrollment form. It is highly recommended that the effective date be within one month of the contract date. | Employee benefits for the first benefit year are prorated Yes <input type="checkbox"/> No <input type="checkbox"/> <i>(If not specified, benefits are not pro-rated)</i> | Unused benefits at fiscal year end will: Rollover* <input type="checkbox"/> Forfeit <input type="checkbox"/> * maximum 1 year <i>(If not specified, benefits will Rollover)</i> |

Specify the annual fixed maximum benefit level you want for each classification of employee participating in the plan. If you want different benefit levels for employees without dependants, please indicate the amount in the appropriate column.
Please Note: Benefit levels are granted on an annual basis unless otherwise noted. If you choose a benefit level on an accumulating monthly basis, please check the 'monthly' box.
 Benefits for Full-Time Employees (code 3 below) should be at least 10% of Executive (code 1).

| EMPLOYEE CLASSIFICATION | | FIXED ANNUAL BENEFIT LEVEL | | | |
|-------------------------|-------------------|----------------------------|--------------------|-----------------------------------|--------------------------|
| CODE | DESCRIPTION | WITH DEPENDANTS | WITHOUT DEPENDANTS | % CO-PAYMENT REQUIRED BY EMPLOYEE | MONTHLY |
| 1 | Executive | \$ | \$ | % | <input type="checkbox"/> |
| 2 | Senior Management | \$ | \$ | % | <input type="checkbox"/> |
| 3 | Full Time | \$ | \$ | % | <input type="checkbox"/> |
| 4 | Part Time | \$ | \$ | % | <input type="checkbox"/> |
| 5 | Hourly | \$ | \$ | % | <input type="checkbox"/> |

Please call 1 (866) 527-0123, ext 1 if you have any questions.

Arranged by:



Benefit Plan Administration

3)

FUNDING OPTIONS

A funded trust account is required for any groups with arms-length employees. An initial deposit is required with the submission of this contract. Please contact STRATA Benefits regarding the calculation of the monthly deposit amounts.

| OPTION | AMOUNT | DESCRIPTION |
|--|--------|---|
| <input type="checkbox"/> Monthly PAC | \$ | Monthly auto-withdrawal from employer account into trust account for specified amount |
| <input type="checkbox"/> Monthly Invoice | \$ | Monthly invoice mailed for specified amount |
| <input type="checkbox"/> With Claim | | Each claim is submitted with the required funds for that claim Note: This option is not available for companies with Arms-length employees. Claims submitted with funds that exceed \$5,000 will be held for five (5) business days |

4)

EMPLOYEE INFORMATION

| | |
|---|---|
| When does the employee become terminated from the plan? <i>(If not specified, employee will be terminated in 30 days)</i> | Future Employees are eligible <i>(If not specified, 0 days)</i> |
| _____ days after employment termination | _____ days / months following hire date |
| Number of Eligible Employees: | Are Employees allowed to opt out of plan? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If not specified, 'Yes' to both)</i> Are Employees allowed to opt back in? <input type="checkbox"/> Yes <input type="checkbox"/> No (Attach employee enrollment or opt out forms for the total number of eligible employees) Note: Employer is responsible for notifying Olympia Trust when there are any changes to the plan. |
| Dependant Children are covered to what age? <i>(if not specified, coverage is restricted to those under age 18 or up to age 25 if enrolled full-time in a recognized post-secondary institution)</i> | NOTE: Disabled adult children and full-time students may be excepted from this rule, written notification of either situation is required. |

Please list ALL participating employees (Attach another page if necessary).

| CODE <small>(from page 1)</small> | FIRST NAME | INITIAL(S) | LAST NAME |
|--------------------------------------|------------|------------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ADMINISTRATIVE SERVICES AGREEMENT

BETWEEN:

OLYMPIA TRUST COMPANY, of 2300 – 125 9th Avenue SE
Calgary, Alberta T2G 0P6 (hereinafter called “Olympia”)

– and –

(please print ‘Legal Company Name’ from page 1, hereinafter called “the Employer”)

WHEREAS:

- (A) The Employer has established a Private Health Services Plan, a summary of which is included in this document, for its employees and their dependants (hereinafter called the Employee Health Care Plan): and
- (B) Olympia is engaged in the business of providing financial, administrative and trustee services;

NOW THEREFORE Olympia and the Employer hereby agree as follows:

Responsibilities of Olympia

Olympia shall provide the following services to the Employer:

1. Olympia will provide consultation to the Employer with regard to requirements to establish an Employee Health Care Plan for its employees.
2. Olympia will assist the Employer with implementing the Employee Health Care Plan.
3. Olympia will administer and manage the Employee Health Care Plan on an ongoing basis.
4. Administration of the Employee Health Care Plan will include but not be limited to the following:
 - a) Establishing Accounts for eligible Employees, as authorized by the employer.
 - b) Confirming that claims meet eligibility requirements.
 - c) Monitoring claim pools to ensure account maximums are not exceeded.
 - d) Establishing client reporting procedures.
 - e) Processing elections on year end account balances.
 - f) Processing and distributing claims from accounts.
 - g) Arbitrating contestable claims between Employee and Employer.
5. Olympia will follow the guidelines and procedure manuals set forth by respective Provincial Health Information Acts and the Federal Freedom of Information and Privacy Protection Act.
6. Olympia will hold all monies received from the Employer in trust which bears no interest to the employer.
7. Olympia will be entitled to all interest earned on trust funds.

Responsibilities of the Employer

1. The Employer will ensure that the plan remains funded as outlined in the attached Fee Schedule, in a manner necessary to meet its obligations to its employees and Olympia. In the event that the employer fails to fund the plan as required, Olympia is under no obligation to, and will not pay out claims submitted by the employees.
2. The Employer shall provide Olympia with a current record of all eligible employees and dependants covered under the plan.
3. The Employer shall notify Olympia immediately about changes affecting the eligibility of any employees and/or dependants in a manner that is satisfactory to Olympia.
4. The Employer shall maintain a registry of all eligible employees signifying which employees are participating in the Employee Health Care Plan and which employees are opting out.

Other Terms

1. The Employer authorizes Olympia to apply payments from the Employer’s account in settlement of eligible benefits payable to employees under the Employee Health Care Plan and settlement of administration fees due to Olympia, and to make adjustments to accounts to comply with the Fee Schedule of this agreement.
2. Olympia trust shall not be liable in the event that it has paid a benefit for which an employee was not eligible because the Employer failed to supply Olympia with timely or accurate information in a manner satisfactory to Olympia.
3. This agreement can be terminated immediately by either party upon written notice to the offices of the other party. Termination of this agreement constitutes termination of the Employee Health Care Plan.
4. In the event this agreement is terminated, Olympia shall have no obligations under the Employee Health Care Plan beyond paying claims incurred prior and including the date of termination. The Employer shall be required to fund its obligations under this agreement, including fees and applicable taxes due to the administrator, up to and including the date of termination.
5. This agreement, together with the Employee Enrollment forms, Opt Out forms (if applicable), Optional Insurance forms (if applicable) and the Client Account Information File, copies of which are attached and made a part hereof, constitutes the entire agreement.
No agent or other persons has authority to waive any conditions or restrictions of this agreement; to make or modify this agreement; or to bind Olympia by making any promise or representation or by giving or receiving any information.
6. Time is of the essence in the agreement.
7. In addition, Federal and Provincial sales taxes will be levied on fees when applicable. Olympia Trust G.S.T. Registration #R898780739.

