Retiree Plans

Johnston group

JG10-JG

APPLICATION FORM

Office Use Only

Eligibility confirmed _____

Effective date of coverage _____

Firm number _____

Certificate number _____

General Information and Prior Coverage Confirmation

Applicant's Last Name _____ First Name _____ Initial _____

Address _____

City _____ Province _____ Postal Code _____

Phone (_____) _____ Email Address _____

Language of preference: ❑ English ❑ French

Eligibility for this plan is limited to individuals who have been an Owner, Dealer, Principal, or Executive for the last 5 years, and who have been covered under a Johnston Group Inc. administrated plan for the past 2 years.

Please indicate the current/previous Chambers Plan, Maximum Benefit, or Johnston Group administrated plan you were covered under:

Firm Name _____

Firm # _____ Certificate # _____ Date coverage ended (YYYY/MM/DD) _____

Please provide contact information from your previous Chambers Plan, Maximum Benefit, or Johnston Group administrated plan, should we need to verify your eligibility:

Name _____ Phone (_____) _____

Title _____ Email Address _____

Plan Choice

I apply for Retiree coverage of:

❑ Plan A with (select one)	❑ Drug Option	❑ No Drugs
❑ Plan B with (select one)	❑ Drug Option	❑ No Drugs
❑ Plan C with (select one)	❑ Drug Option	❑ No Drugs

For individuals to be eligible for any benefits under the Emergency Travel benefit, coverage must be in effect prior to departure. If individuals are out of the country when the plan goes into effect, the travel coverage will not go into effect until they return to their province of residence.

Individuals To Be Covered

Individuals covered under the above group health and dental plan are eligible for Retiree coverage. Please indicate the individuals applying for coverage:

Extended health care coverage for a dependent who is hospitalized on the date they become eligible for coverage, other than a newborn child, will be delayed until the first day immediately following his/her discharge from the hospital.

Individual	First & Last Name	Gender (M/F)	Date of Birth YYYY/MM/DD
Applicant			
Spouse			
Dependent Child*			
Dependent Child*			

*__Over-age students__ must complete a *Request for Over-age Dependent Coverage*. __Incapacitated over-age dependents__ must complete a *Request for Over-age Disabled Dependent Coverage* prior to reaching the maximum dependent age for consideration of coverage. Please contact Johnston Group for the necessary form(s) .

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Payment

I hereby tender an initial premium of $_____ payable to Johnston Group Inc. which represents the premium amount for one month of coverage based on the current rate table.

I authorize Johnston Group Inc. through the Toronto-Dominion Bank to make automatic deductions from the account below on the 1st day of each month. I will receive notice of the debit approximately 3 business days before the 1st of the month. However, I will not receive notice of subsequent month's debits until such time as the amount changes.

I understand that this agreement may be revoked at any time by providing 30 days written notice. I understand that I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. I understand that I may obtain further information on my right to cancel / recourse rights by contacting my financial institution, or by visiting www.cdnpay.ca.

Financial Institution Name _____

Branch Address _____ City _____ Province _____

To ensure we accurately encode all the necessary information, please enclose a sample cheque marked "**Void – Premium Payment**."

Request for Direct Deposit of Extended Health and Dental Claims

I hereby authorize Johnston Group Inc. to make a direct deposit of my benefit payment(s) to:

❑ the same chequing account shown above, or

❑ to a different chequing account indicated below:

Financial Institution Name _____

Branch Address _____ City _____ Province _____

To ensure we accurately encode all the necessary information, please enclose a sample cheque marked "**Void – Direct Deposit**."

Declaration & Authorization

I/WE hereby apply for Retiree Coverage. I certify that the information provided herein is true, accurate and complete; and that I am or have been covered under a group health and dental plan indicated above within the last 60 days. I understand that my dependents and I must currently be covered under my Provincial Health plan and remain covered in order to be eligible for coverage. I authorize Group Medical Services (GMS), Johnston Group Inc., their agents and service providers to use and exchange information for the purposes of underwriting, administering and adjudicating claims under this benefit plan with any person or organization having relevant information about me, my spouse or dependents. I confirm I am authorized to act on behalf of my spouse and/or dependents for such purposes. A photocopy of this authorization is as valid as the original and shall remain in effect throughout the duration of my coverage under this benefit plan.

Applicant's Signature _____ Date _____

Please return the completed application and first month's premium to:
Retiree Program
National Service Centre
1051 King Edward Street
Winnipeg, MB R3H 0R4

GMS and Johnston Group Inc. are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that they collect, use, retain and disclose in the course of conducting business.