



B4B Benefits for Business Association Plan



Finally! Easy access to comprehensive and affordable Health and Dental Benefits and Income Protection.

Welcome to the B4B Benefits for Business Association Plan.

This page will act as your guide to the most flexible Association Benefits Program available in Canada today – the B4B Benefits for Business Association Plan.

Flexible Benefits:

You choose **only those benefits** you really want – from the 4 Modules offered.

Extended Health & Dental Benefits:

1. Module 1 – Extended Health and Dental Benefits

- 3 available plans – Basic, Select or Plus (Refer to accompanying plan for coverage and cost details.)

Optional Benefits:

2. Module 2 - Income Protection Program

- Protect yourself against temporary or permanent loss of income as a result of injury, illness and accidental death and dismemberment. (Refer to accompanying plan for coverage and cost details.)

3. Module 3 – Life Insurance – from \$50,000+ depending on your needs

- Access to lowest premiums available in marketplace.
- Types available - Term10, Term20, Term100, Universal Life, Permanent Participating
- Coverages available - Single Life, Multiple Lives, Joint First and Last to Die, Key Person, Buy/Sell Insurance.

4. Module 4 - HCSA's (Health Care Spending Accounts) – Ensures Cost Predictability.

- Ideal for major Health and Dental expenses not usually covered by association or group plans; for example, Orthodontics, Laser Eye Surgery, etc.

Decline to Participate Form

*****Note:** All B4B Benefits for Business Association Plan members must sign a **Decline to Participate Form** for those optional benefits they choose not to purchase.

No Medical Exam required! – Coverage is subject to the Insurer's approval of a medical questionnaire. To participate, simply complete the Application Form(s) and the Personal Health Declaration and mail with a "VOID" cheque to B4B Benefits for Business at the address indicated.

B4B Benefits for Business Association Plan

B4B Benefits for Business is acting in the capacity of an Insurance Broker in bringing the **B4B Benefits for Business Association Plan** to the public. This program is not directly available to the public and is only available to them through specified brokers who have an associate contract with **Alternative Benefits Solutions Inc.**, the owners of this proprietary product.

Why delay?

Apply for your Association Plan today! Just follow the simple steps outlined in the attached documents, and return all forms to:

Jim Sumner, B.A., Cert. Ed., CFP
6389 120th Street
Box 98029
North Delta, BC V4E 2B0



Phone: 604.572.6745
Fax: 604.635.0474
Cell: 778.846.4040
E-mail: b4b@dccnet.com

B4B

Benefits for Business Association Plan

Flexible & affordable Health & Dental Benefits for our Members

Finally! Easy access to comprehensive Health & Dental Benefits

Until now, access to basic Health & Dental benefits has been all but impossible for many people.

Recognizing the enormous need for **affordable Health & Dental protection**, we're pleased to make available a unique plan - the most flexible benefits program available in Canada today - **The B4B Benefits for Business Association Plan**.

The Program offers a unique combination of the basic Health & Dental coverage you want - at a price

you'll appreciate - plus the flexibility of tailoring coverage with optional benefits that are normally only available in large group programs.

Your plan, your choice:

Different people have different needs.

The B4B Benefits for Business

Association Plan lets you choose the coverage that's right for you, offering three levels of protection: **Basic**, **SELECT** or **Plus**, all available with or without Dental coverage.

Benefits for Business



Real-world, needs-related coverage options



Comprehensive coverage:

The **B4B Benefits for Business Association Plan** is designed to give you the basic coverage you need, with the flexibility of customizing your coverage with Optional Benefits.

- Ambulance & Hospital
- Private Nursing & Home Support
- Medical Equipment & Supplies
- Vision & Hearing Aids
- Prosthetics & Orthotics
- Out-of-Country Coverage
- Catastrophic Drug Coverage

Available coverage includes:

- Extended Health Care with or without Dental Benefits
- Prescription Drugs
- Paramedical Services

Optional Benefits:

- Critical Illness Insurance
- Accidental Death & Dismemberment Insurance
- Disability Insurance

How To Apply for Coverage

Please review the details of the coverage available for Health & Dental and Optional Plans on the next page, and decide which **B4B Benefits for Business Association Plan** is right for you. If you require assistance or further information, please contact us.

No Medical Examination required:

Coverage is subject to the Insurer's approval of a medical questionnaire. To participate, simply complete the Application Form and the Personal Health Declaration and mail with a VOID cheque to the address indicated. Faxed Applications are also acceptable.

Jim Sumner, B.A., Cert. Ed., CFP
6389 120th Street
Box 98029
North Delta, BC V4E 2B0



Phone: 604.572.6745
Fax: 604.635.0474
Cell: 778.846.4040
E-mail: b4b@dccnet.com

B4B Benefits for Business Association Plan Summary

EHC	Basic	SELECT	Plus
Medical Underwriting Requirements	Medical Questionnaire Required for Coverage Approval	Medical Questionnaire Required for Coverage Approval	Medical Questionnaire Required for Coverage Approval
EHC Benefits	Lifetime Benefit Maximum: \$250,000	\$25,000 / policy year; No Lifetime Maximum	Lifetime Benefit Maximum: \$250,000
Reimbursement	100% except prescription drugs	80%	100% except prescription drugs
Pay-direct card	Yes	Yes	Yes
Prescription Drugs:			
Annual Maximum	\$3,350 per policy year; generic drugs	\$5,000 per policy year; generic drugs unless Physician specifies "No substitution"	\$4,350 per policy year; name brand drugs
Reimbursement	70% of 1st \$500; 100% of next \$3,000	80%	80% of 1st \$500; 100% of next \$4,000
Dispensing Fee Cap	\$7.50 per prescription	N/A	N/A
Hospital:			
Room	semi-private	semi-private	semi-private or private
Daily Maximum	up to \$150 / day	up to \$170 / day for 30 days	up to \$200 / day
Maximum	\$4,500 per policy year	\$5,100 per policy year	\$25,000 per policy year
Vision Care:			
Frames / Lenses	\$150 / 2 years after 6 month waiting period	\$150 / 2 years after 6 month waiting period	\$250 / 2 years after 6 month waiting period
Eye Exams	\$100 / 2 years after 6 month waiting period	\$100 / 2 years after 6 month waiting period	\$100 / 2 years after 6 month waiting period
Paramedicals: (Acupuncturist, Chiropractor, Chiropodist, Physiotherapist, Osteopath, Podiatrist, Registered Massage Therapist, Naturopath)			
Per Practitioner Max.	\$450 per policy year	\$300 per policy year on a "top-up" basis to any provincial benefits payable; subject to a maximum of \$50 per visit	\$500 per policy year
Per Visit Max.	\$50		\$50
Speech Therapist	maximum of \$60 first visit, \$40 subsequent		maximum of \$60 first visit, \$40 subsequent
Chiropractic X-Rays	\$35 per year		\$35 per year
Psychologist	maximum of \$75 first visit and \$60 subsequent; limited to 15 visits per year	up to \$360 per two policy years	maximum of \$75 first visit and \$60 subsequent; limited to 15 visits per year
Medical Appliances & Support:			
Home Support, Durable Medical Equipment, Prosthetic Appliances, Orthotics	Home Support: \$3,000 / year Equipment: \$3,000 / year Private Duty Nursing: \$3,000 / year Orthotics: \$225 / year Prosthetics \$3,000 / year	Medical & Surgical Supplies: \$1,500 / year Equipment & Prosthetics: \$1,750 / year Private Duty Nursing: \$2,000 / year Orthotics: \$150 / year	Home Support: \$3,000 / year Equipment: \$3,000 / year Private Duty Nursing: \$3,000 / year Orthotics: \$225 / year Prosthetics \$3,000 / year COMBINED ANNUAL MAXIMUM FOR ALL SERVICES ABOVE IS \$7,500
Ambulance	\$10,000 ground transportation; \$4,000 air transport per policy year	services not covered by provincial benefits up to \$250 per trip	\$10,000 ground transportation; \$4,000 air transport per policy year
Hearing Aids	\$400 every 4 years	\$300 every 5 years	\$500 every 4 years
Accidental Dental	\$2,500 per policy year	\$2,500 per policy year	\$3,000 per policy year
Out-of-Country Travel Insurance:	\$1 Million for trips up to 30 days, \$100 deductible per claim; includes Emergency Travel Assistance Services	\$1 Million for trips up to 30 days, \$100 deductible per claim; includes Emergency Travel Assistance Services	\$1 Million for trips up to 30 days, \$100 deductible per claim; includes Emergency Travel Assistance Services
DENTAL	Basic	SELECT	Plus
Preventative Services	80% reimbursement; no waiting period; 8 units scaling; 9 month recall; Oral Surgery; Endodontics; Periodontics.	80% Reimbursement: Basic Preventative Care including: diagnostics, laboratory services, surgical services, denture repair, Endodontics, Periodontics (at 50%), oral surgery, anesthetic, and minor restorations.	80% reimbursement; no waiting period; exams, cleaning, scaling every 6 months; fillings, x-rays, fluoride, space maintainers; extractions; anesthesia; Endodontics; Periodontics; denture repair.
Major Restorative	not included	not included	available Year 3+ at 60% reimbursement; crowns, bridges, dentures & orthodontics
Orthodontia	not included	not included	see above
Annual Maximums	80% to \$500 year 1; 80% to \$750 year 2+	up to \$1,500 per person per policy year	80% to \$500 year 1; 80% to \$750 year 2; 80% to \$1,000 year 3 & 4; and \$1,250 year 5 including combined Perio/Endo max. of \$500/year; 50% Periodontics reimbursement

OPTIONAL BENEFITS: (available to all coverage levels)

Catastrophic Drug Coverage: Increases the annual drug maximum to \$25,000 per family member.

Disability Insurance Benefits: Available coverage includes Temporary Total Disability, Permanent Total Disability and Accidental Death & Dismemberment.

Critical Illness Benefit: Lump sum benefit paid if you are diagnosed with one of TEN life threatening illnesses and survive for 30 days. Some conditions apply.

Accidental Death & Dismemberment Insurance: 24 hours per day / 365 days per year individual or family coverage in units of \$50,000 to \$300,000.

**Benefits for Business Application for Insurance - Basic, Plus or SELECT Programs**

Please submit this Application and 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 us at **604-572-6745**

Section 1: General Information

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	
HOME ADDRESS			CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE		WORKPLACE TELEPHONE		FAX	
EMAIL ADDRESS					
YOUR COMPANY NAME			YOUR EMPLOYMENT STATUS <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> CONTRACTOR <input type="checkbox"/> INCORPORATED		
YOUR BUSINESS ADDRESS			CITY	PROVINCE	POSTAL CODE

Section 2: Coverage Selection & Plan Choice

1. Please indicate your level of coverage:

Single Two Parent Family with _____ Child / Children
 Couple Single Parent Family with _____ Child / Children

2. Please choose your Benefits Program: Basic Plus SELECT

3. Please choose Extended Health Care ONLY or Extended Health Care + Dental: EHC ONLY EHC + DENTAL

Section 3: Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	If Child Over 21
Spouse:				
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED
Child:				<input type="checkbox"/> STUDENT <input type="checkbox"/> DISABLED

If a Child is over age 21, state if a Student or Disabled. Students must provide proof of attendance at school (ie. a copy of their student card).

If your Spouse is currently insured under another Health Care benefit plan, please provide the following information:

SPOUSE'S EMPLOYER (OR NAME OF THE OTHER PLAN)	OTHER HEALTH CARE PLAN POLICY NUMBER	INSURANCE COMPANY NAME
---	--------------------------------------	------------------------

Section 4: Declaration & Authorization (please remember to attach a cheque marked "VOID" to enable monthly premium withdrawals)

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 the Plan Administrator, Alternative Benefit Solutions Inc., 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 date of August 1st each year.

Signed at: _____ this _____ day of _____, _____ Applicant's Signature _____
CITY/TOWN PROVINCE DATE MONTH YEAR

Section 5: Privacy & Confidentiality

We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to Alternative Benefit Solutions Customer Service, the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Mail or Fax your completed application to:

Jim Sumner, B.A., Cert. Ed., CFP
6389 120th Street
Box 98029
North Delta, BC V4E 2B0



Phone: 604.572.6745

Fax: 604.635.0474

Cell: 778.846.4040

E-mail: b4b@dccnet.com

Basic or Plus Program Rates:

British Columbia - SINGLE & COUPLE RATES											
Age Group	EHC ONLY				Age Group	EHC + DENTAL					
	Single		Couple			Single		Couple			
	Basic	Plus	Basic	Plus		Basic	Plus	Basic	Plus		
21-44	\$46.73	\$69.41	\$84.12	\$117.99	21-44	\$84.97	\$126.20	\$152.95	\$214.53		
45-54	\$54.40	\$86.70	\$97.91	\$147.40	45-54	\$98.90	\$157.64	\$178.02	\$268.00		
55-59	\$63.66	\$92.94	\$114.59	\$158.00	55-59	\$115.75	\$168.99	\$208.35	\$287.28		
60-64	\$71.88	\$103.75	\$129.38	\$176.38	60-64	\$130.69	\$188.65	\$235.24	\$320.70		

British Columbia - FAMILY RATES (TWO PARENTS with Dependent Children)													
Age Group	EHC ONLY						Age Group	EHC + DENTAL					
	with 1 Child		with 2 or 3 Children		with 4 + Children			with 1 Child		with 2 or 3 Children		with 4 + Children	
	Basic	Plus	Basic	Plus	Basic	Plus		Basic	Plus	Basic	Plus	Basic	Plus
21-44	\$107.35	\$152.44	\$134.18	\$195.81	\$171.78	\$255.90	21-44	\$195.17	\$277.16	\$243.96	\$356.02	\$312.33	\$465.28
45-54	\$119.60	\$178.38	\$145.28	\$219.68	\$181.97	\$278.04	45-54	\$217.46	\$324.33	\$264.15	\$399.43	\$330.86	\$505.53
55-59	\$134.43	\$187.74	\$158.72	\$228.29	\$194.30	\$286.03	55-59	\$244.41	\$341.35	\$288.58	\$415.08	\$353.26	\$520.06
60-64	\$147.57	\$203.96	\$170.63	\$243.21	\$205.22	\$299.87	60-64	\$268.32	\$370.83	\$310.24	\$442.21	\$373.13	\$545.22

British Columbia - SINGLE PARENT FAMILY RATES (ONE PARENT with Dependent Children)													
Age Group	EHC ONLY						Age Group	EHC + DENTAL					
	with 1 Child		with 2 or 3 Children		with 4 + Children			with 1 Child		with 2 or 3 Children		with 4 + Children	
	Basic	Plus	Basic	Plus	Basic	Plus		Basic	Plus	Basic	Plus	Basic	Plus
21-44	\$67.09	\$101.62	\$92.53	\$141.89	\$129.16	\$199.92	21-44	\$121.98	\$184.77	\$168.25	\$257.99	\$234.84	\$363.50
45-54	\$74.75	\$118.92	\$100.20	\$159.19	\$136.82	\$217.22	45-54	\$135.91	\$216.22	\$182.17	\$289.44	\$248.76	\$394.95
55-59	\$84.02	\$125.16	\$109.46	\$165.43	\$146.09	\$223.46	55-59	\$152.76	\$227.56	\$199.02	\$300.78	\$265.61	\$406.29
60-64	\$92.23	\$135.97	\$117.68	\$176.24	\$154.30	\$234.27	60-64	\$167.70	\$247.22	\$213.96	\$320.44	\$280.55	\$425.95

Instructions:

To determine your monthly rate for **Basic** or **Plus** coverage, find the amount for your chosen Program, age band and level of coverage to box (1) below.

Notes: Rates for **SELECT** coverage below. Rates for other Provinces and age groups are available upon request.

Basic or Plus Health Benefits Monthly Cost: \$ (1)

SELECT Program Monthly Rates:

(For Families with more than 4 children, please call for a Rate Quote)

British Columbia							
<input type="checkbox"/> 1. Extended Health Care Only (80% Reimbursement)				<input type="checkbox"/> 2. Extended Health Care + Dental (80% Reimbursement)			
Single:	Couple:	Family 1-2 children	Family 3-4 children	Single:	Couple:	Family 1-2 children	Family 3-4 children
\$43.56	\$83.60	\$94.60	\$105.60	\$79.20	\$152.00	\$172.00	\$192.00

SELECT Health Benefits Monthly Cost: \$ (2)

Catastrophic Drug Protection Monthly Rates:

British Columbia			
Deductible:	\$3,000 (Basic Program)	\$4,000 (Plus Program)	\$5,000 (SELECT Program)
Single	\$4.43	\$3.75	\$3.07
Couple	\$6.82	\$5.63	\$4.43
Family	\$8.52	\$7.33	\$6.14

Catastrophic Drug Protection is designed to provide additional protection for potential catastrophic drug claims that go beyond the coverage of the plan selected. The rider will extend payment of drug claims that may exceed the limits of the underlying prescription drug benefit of the plan selected (Basic \$3,000 / Plus \$4,000 / SELECT \$5,000) to \$25,000 per person (\$100,000 Family maximum)

Catastrophic Drug Protection Monthly Cost: \$ (3)

Section 7: Optional Benefits (Please review the accompanying Income Protection Program brochure before completing this section)

Optional Benefits can be selected to enhance your overall protection or address specific personal needs. Benefits are detailed in a separate brochure and a separate application form is required. Please review the Income Protection Program brochure, then return here to indicate which, if any, of the Optional Benefits you will be applying for.

Temporary Total Disability Benefits: Requires separate Application Form. Please complete the Income Protection Program Application that follows.

Permanent Total Disability Benefits: Requires separate Application Form. Please complete the Income Protection Program Application that follows.

Critical Illness Benefit: Requires separate Application Form. Please complete the Income Protection Program Application **AND** ACE INA Health Statement.

Accidental Death & Dismemberment: Requires separate Application Form. Please complete the Income Protection Program Application that follows.

Section 8: Calculate your Monthly Cost: (not including Optional Benefits)

Total the amounts from boxes (1), (2) and (3) to determine your monthly benefits cost. The cost of any Optional Benefits you have selected will be added to this amount, and the total amount will be withdrawn from your financial institution each month. Please attach a cheque marked "VOID" to enable these monthly withdrawals.

Your Total Monthly Benefits Cost: \$

If you require assistance, please contact us at one of the numbers below:

Jim Sumner, B.A., Cert. Ed., CFP

Phone: (604) 572-6745 Cell: (778) 846-4040 Fax: (604) 635-0474 Email: b4b@dccnet.com



Please remember to complete in detail and attach the required Personal Health Declaration(s) and to attach a cheque marked "VOID" to enable monthly premium withdrawals.



Personal Health Declaration



Please complete this Personal Health Declaration in full. In particular, if you answer "YES" to any of the medical questions below, please provide details on reverse. Questions or need further assistance? Please call us at 604-572-6745.

Section 1: Applicant Information

APPLICANT NAME		DATE OF BIRTH (DAY / MONTH / YEAR)	
SPOUSE'S NAME (IF APPLICABLE)		DATE OF BIRTH (DAY / MONTH / YEAR)	
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)	
APPLICANT'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	APPLICANT'S HEIGHT _____ <input type="checkbox"/> ft/in or <input type="checkbox"/> cm	APPLICANT'S WEIGHT _____ <input type="checkbox"/> lbs or <input type="checkbox"/> kg	
SPOUSE'S SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SPOUSE'S HEIGHT _____ <input type="checkbox"/> ft/in or <input type="checkbox"/> cm	SPOUSE'S WEIGHT _____ <input type="checkbox"/> lbs or <input type="checkbox"/> kg	
DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)		DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)	
DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)		DEPENDENT'S NAME & DATE OF BIRTH (DAY/MONTH/YEAR)	

Section 2: Health Declaration

Have you or any of your dependents 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	SPOUSE	DEPENDENTS
1. Have you ever been treated for, counselled for, received advice for or ever had any known indication of:			
a) Heart, Chest Pain/Angina, Heart Attack, Arrhythmia, Murmur, Dizziness, Fainting or Blood Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
c) Diabetes, Colitis or Crohn's?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
g) Infertility / Reproductive Disorder, Menopause, Prostate Disorder?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
h) Chronic Headaches, Migraines or recurrent infections?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
l) Auto-Immune Disorders - Systemic Lupus, Erythematosus (S.L.E.), Scleroderma?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
n) Skin Disorder (including Acne)?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
o) Alcoholism or Drug Abuse/Dependency?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
p) Other Condition/Disease/Disorder/Injury - Please specify: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	<input type="checkbox"/> YES <input type="checkbox"/> NO	<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	
NAME OF SPOUSE'S PHYSICIAN		ADDRESS	
LAST VISIT (MONTH / YEAR)	REASON	RESULT	

Section 3: Details for questions answered "YES"

Please provide details for any question answered "YES" on reverse. If additional space is required, please attach a separate sheet.

Question #	Name of Applicant, Spouse or Dependent	Illness / Condition	Date of onset	Frequency of episodes	Date of recovery	Medication / Treatment	Daily Dosage	Approximate monthly cost

Section 4: Declaration & Authorization

I understand that, to be eligible for the insurance for which I am applying, I must at all times be covered under my provincial government health plan and be a Canadian resident.

I agree that the statements and answers in this Declaration, on any medical examination and in any written statements or answers furnished as evidence of my insurability shall form the basis of any insurance granted under the terms of the policy issued me. I understand that Echelon General Insurance Company, or Lloyds of London (certain underwriters), (the Insurers) or their service providers reserve the right to verify the answers provided to the questions contained in this Personal Health Declaration at the time of any claim for benefits under the policy issued to me. I declare that all statements and answers recorded in this Declaration are as given by me and are true and complete.

I hereby authorize the Insurer or its service providers, for underwriting and administration of insurance and claims paying purposes only:

- (a) To gather only that information necessary for the objective of the Health & Dental Benefits or Disability Benefits file from any person or organization that has personal information relating to me, including other insurers, physicians and medical institutions, investigation and credit reporting agencies, and all persons or organizations likely to have personal information relevant to the objective of this file;
- (b) To disclose only the necessary personal information it has relating to me to these same persons and organizations, or as required by law;
- (c) To request a personal investigation report relating to me.

A photocopy of this Authorization shall be as valid as the original.

Dated at _____ this _____ day of _____ 20_____

Applicant's Signature _____

Signature of Spouse (if dependent coverage applied for) _____

Signature of Dependent(s) - (if above age of majority) _____

This authorization is valid for the period required to achieve the ends for which it was requested.

MAIL OR FAX TO:

Jim Sumner, B.A., Cert. Ed., CFP
 6389 120th Street
 Box 98029
 North Delta, BC V4E 2B0



Phone: (604) 572-6745
 Fax: (604) 635-0474
 Cell: (778) 846-4040
 E-mail: b4b@dccnet.com

To the Attention of: Mr. Jim Sumner, B.A., Cert. Ed., CFP

Re: B4B Benefits for Business Association Plan – Optional Benefits

Decline to Participate Form

Dear Mr. Sumner:

I have reviewed the Optional Benefits in the B4B Benefits for Business Association Plan. This is to inform you that I have decided not to purchase the following products at this time (marked with an "x") I am aware that in the future should I wish to purchase any of the Optional Benefits available at that time, I may be declined for health, lack of sufficient employment or other reasons.

Please indicate with an "x" those Optional Benefits you do not wish to purchase:

- _____ - Life Insurance Benefit
- _____ - Temporary Total Disability Benefit
- _____ - Permanent Total Disability Benefit
- _____ - Critical Illness Benefit
- _____ - Accidental Death and Dismemberment Benefit
- _____ - Health Care Spending Account

Since I have voluntarily declined to purchase those Optional Benefits indicated by an "x" above, I will not hold you financially responsible for not having this insurance in place.

I acknowledge that I was informed in all aspects of the insurance products presented and I have voluntarily declined to purchase them.

Sincerely,

Signature

Print Name

Signed at _____ this ____ day of _____ 200__

In the presence of

Witness

Print Name