DAEDALUS
GROUP

CONSULTANT BENEFIT ENROLLMENT

Group Benefit Program for S.i. System Contractors

The Daedalus Group Limited, a leading marketer of group benefit plans, and GroupSource, one of the best known Third Party Administrators of group benefits plans in Canada, want to help protect you and your family and make sure you have peace of mind when it comes to life's unexpected events. Through our group benefits plan, S.i. Systems Contractors can expect comprehensive coverage for health and dental care and better value for the dollars spent.

Guaranteed Coverage

With our Contractor benefit program there are no medical questions to answer and no pre-existing condition exclusions.

Better Coverage at Competitive Prices

Unlike many individual benefits plans where up to 45% of your premiums can go towards administrative fees, last year plan members in aggregate received 80% of their premiums back in paid claims. We're confident that our program offers contractors a flexible plan with great coverage at reasonable rates. (Coverage summary on next page)

2019 – 2020 Monthly Premiums*

Status	Core Plan	Enhanced Plan
Single	$164.25	$203.15
Couple	$321.94	$399.76
Family	$374.18	$466.37

*Rates do not include applicable provincial sales tax

Eligibility

If you are an active consultant working 30 hours per week on average you can enroll within the first 30 days of the start of your contract or wait until the annual open enrolment period. (September 20th though October 20th)

Coverage Start Date

Your coverage starts the 1st of the month after your application has been approved.

Easy to use

GroupSource, our benefit providers offers Consultants many great tools for accessing their benefits. You can

- Direct submit drug and dental claims through your health care provider. (TELUS e claims)
- Set up direct deposit so payments go straight into your bank account
- Submit claims via your mobile Apple or Android devices
- Talk to a GroupSource customer representative during business hours at 1-800 661-6195
- Monthly premiums are automatically withdrawn from your bank account on the 10th of the month.

Plan Inquiries

Contact Richard Dillabough, The Daedalus Group Limited at 1-866 944-7769 or email him at Richard@daedalusbenefits.ca

Ready to enroll?

Complete the attached enrolment and PAD form and forward the signed originals to

GroupSource
Suite 200 5970 Centre St S,
Calgary Alberta
T2H 0C1

Plan Details[1]

Eligibility	Core Plan	Enhanced Plan
Waiting period	No	No
Average hours per week	30 hrs. per week (min.)	30 hrs. per week (min.)
Medical evidence required	No	No
Pre-existing condition	No	No
Employee Life and AD&D		
Benefit amount	Flat $25,000	Flat $25,000
Reduction schedule	50% at age 65	50% at age 65
Conversion privilege	Yes	Yes
Waiver of premium	Yes	Yes
Dependent Life		
Spouse	$10,000	$10,000
Children	$5,000	$5,000
Optional Life		
Schedule	Units of $10,000	Units of $10,000
Maximum	$250,000	$250,000
Evidence required	Yes	Yes
Extended Health Care		
Deductible Reimbursement	$0	$0
Drugs	80%	80%
Medical Equipment	80%	100%
Paramedical Services	80%	100%
Hospital	100%	100%
Out of Country	100%	100%
Drug Coverage	Prescription required	Prescription required
Generic Substitution	Mandatory	Mandatory
Drug Calendar Maximum	$10,000	$10,000
Dispensing Fee	$5.00 maximum per script	$5.00 maximum per script
Vision Care	$150/24 months	$150/24 months
Paramedical Maximum	$300/per practitioner $40 maximum per visit	$300/per practitioner $50 maximum per visit
Trip Duration	90 days	90 days
Out of Country Maximum	$2,000,000	$2,000,000
Dental Care		
Waiting Period Basic	None	None
Waiting Period Major	24 months	24 months
Deductible	$25 Single $50 Family	No Deductible
Reimbursement - Basic	80%	100%
Periodontal	50%	50%
Endodontic	50%	50%
Major	50% starting in year 3 (0% in years 1&2)	50% starting in year 3 (0% in years 1&2)
Maximums	$1,000 combined	$1,500 combined
Examinations	Every six months	Every six months
Unit of Scaling	Ten units	Ten units
Termination Age	70 years	

[1]This document is only a brief summary of the plan coverage. Any difference between this summary and the plan policies, the plan policies will prevail

MEMBER APPLICATION- GROUP BENEFITS ENROLMENT

please print legibly

Select One Plan: ☐ Core ____ Enhanced ____

1

Member first name	Member last name		
Member address	City	Province	Postal code
Date of birth yyyy/mm/dd	Gender	Personal phone #	
Work email	Personal email		

2

Are you Married or in a common law relationship? ☐ yes ☐ no	If common law, please provide date of cohabitation (yyyy/mm/dd)

List of dependents (spouse, then dependents, oldest first) FIRST name LAST name	Gender	Date of birth yyyy/mm/dd	Relationship
			SPOUSE

3 BENEFICIARY DESIGNATION - GROUP LIFE, BASIC AD&D/ASI AND LONG TERM DISABILITY SURVIVOR BENEFITS (IF APPLICABLE)

If no beneficiary is designated by the member, the benefit is payable to the estate. Percentages must total 100% to be valid.

Name of beneficiary	Relationship to Member	% of benefit	Date of birth yyyy/mm/dd

FOR QUEBEC RESIDENTS ONLY: in Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. if beneficiary is shown as irrevocable, his/her consent is required to change it.	*Quebec Residents Only:* if the spouse is designated as beneficiary, this designation is: ☐ revocable ☐ irrevocable

4 DECLARATION APPOINTING TRUSTEE (Complete if Beneficiary is under the age of majority) *Not applicable in Quebec*

I hereby appoint _____ as Trustee to receive any amount due to any Beneficiary(ies) under the age of majority and declare the receipt of such Trustee shall be good discharge to The Group Insurer(s) for the amount so paid. And I do hereby authorize such Trustee, at his/her discretion, to expend all or any portion of such amount and/or the income there from for the maintenance or education of such beneficiary(ies).

Address of Trustee: _____ Relationship to Beneficiary:_____

5 PLEASE INDICATE YOUR DESIRED COVERAGE LEVEL *(all future changes should be reported to your plan administrator)*

EXTENDED HEALTH CARE (EHC) & DENTAL CARE: _____(S/C/F/O)

S = Self Only (Single) C= Self and One Dependent (Couple)

F = Self and Two or More Dependents (Family) O = No coverage for myself or my Dependents

Note: You must have alternative insurance to opt out of these benefit coverages. Please complete Waiver section below.

6 CO-ORDINATION OF BENEFITS are you or your dependents covered under another benefits plan?

Extended Health Care (EHC)___(Y/N) Coverage Level____(S/C/F) Dental Care:____(Y/N) Coverage Level _____(S/C/F)

7.

MEMBER AUTHORIZATION - PLEASE READ, SIGN AND DATE

I hereby apply for group benefits coverage provided by my employer and authorize the regular deduction from my pay for any contributions to be made by me in relation to benefits. In regard to these and other benefits for which I am applying or will apply, I am providing certain personal information about myself and my family (if appropriate) and I hereby expressly provide consent to my employer, and to GroupSource, the plan insurers and re-insurers, providers and agents to collect, use, and disclose any and all information necessary to establish and maintain my benefits. I also understand that GroupSource will acquire information about me and my family in the course of, but not limited to, the provisions of benefits and satisfying any claims made and responding to insurer or provider requests. I expressly provide consent that GroupSource may disclose such information and all other information to the plan insurers and re-insurers, providers, agents, the employer or anyone necessary for the provision of benefits, in order to respond to insurer or provider requests for the purpose of determining eligibility, administration of benefits in good standing. I understand that no personal information will be disclosed for any other purpose without my consent. GroupSource limits access to those that are required to review the information for the establishment and provision of benefits. I confirm that I am authorized to act on behalf of my spouse and/or dependents for the purposes as set out herein. I declare the information provided with this application is true, complete and accurate. Any copy of this authorization is as valid as the original.

MEMBER SIGNATURE X _____ DATE X _____