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Master Application

Please print and complete each section in full, and ensure that the benefits selected are the same as those quoted.

1. a) Plan Sponsor

Client Name:							
Full Legal Name:							
No. and Street:							
City:		Prov.		Postal Code:			
Nature of Business:							
☐ Corporation	☐ Proprietorship	☐ Partnership	☐ Union	☐ Other:			
Affiliates and Subsidiaries:							

1. b) Contact and Invoicing/ Out of Country Billing Information

Executive Contact Person :		Telephone:	
Fax:		Email:	
Contact Person (Plan Administrator):		Telephone:	
Fax:		Email:	
Contact Person (Plan Invoicing):		Telephone:	
Fax:		Email:	
Contact Person (Out of Country Billing):		Telephone:	
Fax:		Email:	
Contact Person (Other):		Telephone:	
Fax:		Email:	

2. Effective Date

Effective Date:	(Day)	(Month)	(Year)
Drug/Health/Dental Renewal Date:	(Day)	(Month)	(Year)
Out of Country Renewal Date:	(Day)	(Month)	(Year)
Stop Loss Renewal Date:	(Day)	(Month)	(Year)

3. Consulting/Brokerage Firm:

Street		Unit/Suite	
City		Province/State	
Postal/ZIP Code		Country	
Contact:		Telephone:	
Contact E-mail Address			
Fax:		Email:	

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4. Third Party Administrator/Insurance Company:

Street		Unit/Suite	
City		Province/State	
Postal/ZIP Code		Country	
Contact:		Telephone:	
Contact E-mail Address			
Fax:		Email:	

5. Eligible Employees List province(s) where employees reside:

☐ British Columbia	☐ Alberta
☐ Manitoba	☐ Saskatchewan
☐ Ontario	☐ Quebec
☐ New Brunswick	☐ Nova Scotia
☐ Prince Edward Island	☐ Newfoundland Labrador
☐ Yukon	☐ Nunavut
☐ North West Territories	

Number of lives: **(Initial enrolment)**

Certificate Numbers: Provided to ClaimSecure in file transfer

☐ Assigned by ClaimSecure

☐ Payroll / Employee #'s (not to exceed 5 digits)

6. a) Initial Enrolment Information Via:

☐ Spreadsheet (Excel format as provided by ClaimSecure)
☐ Paper Enrolment Form
☐ File Transfer (According to ClaimSecure specifications)

6. b) Future Enrolment Information Via:

☐ Online Web Eligibility Tool
☐ File Transfers (According to ClaimSecure specifications)
☐ E-mail
☐ Spreadsheet (Excel format as provided by ClaimSecure)
☐ Paper Enrolment Form

7. Benefit Selection:

☐ Drug	☐ Hospital
☐ Major Medical	☐ Vision
☐ Dental	☐ Out of Country
☐ HSSA (Health Services Spending Account)	
☐ Stop Loss: ☐ SecurePak Aggregate ☐ SecurePak Specific ☐ SecurePak Specific Plus ☐ SecurePak Ultra	
Attachment Level ($ or %)	Rate: % of Paid Claims
☐ Benefit Booklets	

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9. HR Second Opinion ☐Yes ☐ No

HR Second Opinion Contract Status: --------- (Select from drop-down)

Group Name:			Client #		Group #	
Primary Contact Person:		Telephone:				
Fax:		Email:				
Secondary Contact Person:		Telephone:				
Fax:		Email:				

Effective Date:		(Day)	(Month)	(Year)	
Contract Term:	☐ 1 year $1,500.00	Renewal Date:	(Day)	(Month)	(Year)
	☐ 2 years @ $1,275.00 per year		(Day)	(Month)	(Year)
Termination Date:		(Day)	(Month)	(Year)	

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8. Web Eligibility, Claims, Online Reporting and Client Claims Downloads

- Web Eligibility, Yes ☐ No ☐
- Claims Entry/Query* Yes ☐ No ☐
- All Benefit Query* Yes ☐ No ☐
- Online Reporting Yes ☐ No ☐
- Client Claims Download* Yes ☐ No ☐

*Available to Insurers, Third Party Administrators, Associations and/or Trustees

10. a) Identification Card / eTag Information:

☐ Identification Card:

Client Name/Logo	Yes ☐	No ☐	
Insurer Logo	Yes ☐	No ☐	
Other Logo	Yes ☐	No ☐	Specify: ________________________
Sample Logo on File	Yes ☐	No ☐	Specify: ________________________
Spencer Vision	Yes ☐	No ☐	
Other Card	Yes ☐	No ☐	Specify: ________________________

Logo – different for each division unit (see division unit structure)	☐Yes ☐ No	Specify:
Custom Card	☐Yes ☐ No	Specify:

☐ eTag:

Custom Card	☐Yes ☐ No	Specify:

10. b) Card Mailing Information

Initial cards mailed to:

Provide Contact Name and Address

Future cards mailed to:

☐ **One Location**
Provide Contact Name and Address

OR

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☐ **multiple locations as specified by division/unit breakdown**

Division	Unit	Provide Contact Name and Address

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11. Description of Eligible Division(s) / Unit (Class)(s)

Division	Unit	Policy #	Client #	Language	Division / Unit Description
				☐ Eng. ☐ Fr.	
				☐ Eng. ☐ Fr.	
				☐ Eng. ☐ Fr.	
				☐ Eng. ☐ Fr.	
				☐ Eng. ☐ Fr.	
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12. Waiting Periods:

Indicate Division→				
Indicate Unit →				
Waiting Period Applies?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If Waiting Period applies, please indicate period below:				
☐Drug Benefit				
☐ Extended Health Care				
☐ Dental Care				
☐HSSA				
☐ Out of Country Coverage				
☐ Wellness Benefit				
Of continuous, full-time employment (Y/N)				
If not continuous employment describe				
Applies to present and future employees?				
Applies to future employees only?				

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13. Drug Benefit Yes ☐ No ☐

Indicate Division→					
Indicate Unit (Class)→					
a) Benefit Period: Indicate **CAL** for Calendar Year or **POL** for Policy Year. Where POL is indicated, please state period i.e. June 1					
b) Reimbursement Method: Indicate **EDI** or Paper					
c) Annual Deductible — Yes ☐ No ☐		$	$	$	$
If applicable: ☐ Single ☐ Family					
☐Calendar Year ☐Policy Year					
Do you wish to waive the deductible for the balance of the first year?					
d) Co-Payment (Employee Pays):					
If co-payment consists of <u>both</u> a "flat" dollar amount and %, please indicated if the % is based on the : ☐ Ingredient Amount ☐ Gross Amount					
Compound Claims: If co-payment includes a dispensing fee please specify the co-pay for compound claims ☐Flat Dollar ☐Percentage					
Sliding co-payment: ☐ Individual ☐ Certificate ☐ Calendar Year ☐ Policy Year					
e) Maximum Dispensing Fee Allowance over and above ClaimSecure provincial standards (N/A for Quebec)		$	$	$	$
e) Ingredient Cost Mark-Up over and above ClaimSecure provincial standards		%	%	%	%
f) Special Authorization					
☐ Stoploss Specialty Drug Program					
☐ Specialty Drug					
☐ Other					
g) Plan Type					
h) Maximum — Yes ☐ No ☐					
If applicable: ☐ Individual ☐ Certificate If Maximum is other than unlimited is it ☐ Lifetime ☐ Calendar Year ☐ Policy Year					
i) Benefit Maximum Age					
j) Dependent Maximum Age					
k) Student Maximum Age					
l) Mail Order / PPO — Yes ☐ No ☐					
m) Survivor Benefit ☐ standard 24 months ☐ other					

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Plan Modifications – Indicate below any modifications to standard plan chosen. Indicate maximum(s) if applicable.				
Indicate Division→				
Indicate Unit→				
Inclusions:				
Exclusions:				
Special Authorization Only:				

NOTE: Where coverage specifications differ between the "Schedule of Benefits" and the "Plan Modifications" areas, the specifications under Plan Modifications will apply

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Drug Benefit (con't)	Plan Inclusions	Plan Exclusions
☐ **Plan A / AG** **Prescription Drug Plan** **In the case of a Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary.**	• All drugs which by law or convention require a physician's or dentist's prescription • Insulin supplies which includes needles, syringes and diagnostic tests. • All injectibles including serums, vaccines, and injectible vitamins • Extemporaneous compounds prepared by a pharmacist where at least one of the products within the compound is covered by the drug plan	• Any drug or medication which may be purchased without a prescription. This further excludes over-the-counter (O.T.C.) products whether prescribed or not. • Diabetic supplies such as swabs, rubbing alcohol, lancets, control solution, etc. • Fertility drugs are not covered even if prescribed for therapeutic use • Anti-Smoking agents are not covered even if prescribed for therapeutic use • Anabolic steroids are not covered even if prescribed for therapeutic use • Items deemed cosmetic even if a prescription is legally required • Oral medications for Erectile Dysfunction • Meridia • Contraceptives other than oral • Injectible vitamins for the purpose of weight loss
☐ **Plan B / BG** **Prescription Drug Plan** **In the case of a Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary**	• All drugs which by law or convention require a physician's or dentist's prescription • Most commonly prescribed over-the-counter (O.T.C.) products • Insulin supplies which includes needles, syringes and diagnostic tests • All injectibles including serums, vaccines, and injectible vitamins • Extemporaneous compounds prepared by a pharmacist where at least one of the products within the compound is covered by the drug plan • Hematinic vitamins properly identified in the Compendium of Pharmaceuticals and Specialties	• Diabetic supplies such as swabs, rubbing alcohol, lancets, control solution, etc. • Fertility drugs are not covered even if prescribed for therapeutic use • Anti-Smoking agents are not covered even if prescribed for therapeutic use • Anabolic steroids are not covered even if prescribed for therapeutic use • Items deemed cosmetic even if a prescription is legally required • Oral medications for Erectile Dysfunction • Meridia • Contraceptives other than oral • Injectible vitamins for the purpose of weight loss
☐ **Plan C/CG** **Prescription Drug Plan** **In the case of a Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary**	• All drugs which by law or convention require a physician's or dentist's prescription • Most commonly prescribed over-the-counter (O.T.C.) products • Insulin supplies which includes needles, syringes and diagnostic tests • All injectibles including serums, vaccines, and injectible vitamins • Extemporaneous compounds prepared by a pharmacist where at least one of the products within the compound is covered by the drug plan • Hematinic vitamins properly identified in the Compendium of Pharmaceuticals and Specialties • Most vitamins	• Diabetic supplies such as swabs, rubbing alcohol, lancets, control solution, etc. • Fertility drugs are not covered even if prescribed for therapeutic use • Anti-Smoking agents are not covered even if prescribed for therapeutic use • Anabolic steroids are not covered even if prescribed for therapeutic use • Items deemed cosmetic even if a prescription is legally required • Oral medications for Erectile Dysfunction • Meridia • Contraceptives other than oral • Injectible vitamins for the purpose of weight loss
☐ **Plan 7/7G** **Equivalent to Plan A/AG with the following exceptions:** **In the case of a Generic Plan, the pharmacist will only be reimbursed for the lowest priced substitutable drug, as provided for in the Provincial Drug Benefit Formulary**	• Managed Formulary (general) • All new drugs released after March 1/02	• New generic drugs released on or after March 1/02 (if the brand name is eligible)
☐ **Other:**	•	•

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14. Extended Health Benefit **Yes** ☐ **No** ☐
Hospitalization Benefit **Yes** ☐ **No** ☐
Vision Benefit **Yes** ☐ **No** ☐
Vision - Spencer Health PPO **Yes** ☐ **No** ☐

Indicate Division→						
Indicate Unit (Class)→						
a) Benefit Period: Indicate **CAL** for Calendar Year or **POL** for Policy Year. Where POL is indicated, please state period i.e. June 1						
b) Annual Deductible	Yes ☐	No ☐				
If applicable: ☐ Single ☐ Family ☐ Calendar Year ☐ Policy Year			$	$	$	$
** If Annual EHB Deductible exists – does it incl.						
Major Medical	Yes ☐	No ☐				
Hospital	Yes ☐	No ☐				
Vision	Yes ☐	No ☐				
Do you wish to waive the deductible for the balance of the first year?						
c) Co-insurance (Plan Pays)	Yes ☐	No ☐				
Major Medical			%	%	%	%
Hospital			%	%	%	%
Vision			%	%	%	%
d) Overall Lifetime EHB Max.	Yes ☐	No ☐				
Includes: Major Medical	Yes ☐	No ☐				
Hospital	Yes ☐	No ☐				
Vision	Yes ☐	No ☐				
e) Annual Maximum	Yes ☐	No ☐				
If applicable: ☐ Individual ☐ Certificate ☐ Calendar Year ☐ Policy Year			$	$	$	$
Includes: Major Medical	Yes ☐	No ☐				
Hospital	Yes ☐	No ☐				
Vision	Yes ☐	No ☐				
f) Benefit Maximum Age						
g) Dependent Maximum Age						
h) Student Maximum Age						
i) Vision PPO- Premium Rate - per member per month			$	$	$	$
j) Survivor Benefit ☐ standard 24 months ☐ other						

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Extended Health Benefit

Paramedical Services	**Per Visit Allowance** ☐ Unlimited OR ☐ $ **Annual Maximum** ☐ Per Practitioner OR ☐ All Practitioners Combined

☐ Coverage effective following provincial plan coverage OR
☐ Coverage from first dollar except where Provincial Health Insurance plan prohibits by law

Note: *Paramedical practitioners must be licensed, certified and/or registered within the province the services were incurred.*

Practitioner	Included	Annual Maximum	Physician's Referral Required	Modifications
Acupuncturist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Chiropodist/Podiatrist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Chiropractor	Yes ☐ No ☐	$	Yes ☐ No ☐	
Naturopath	Yes ☐ No ☐	$	Yes ☐ No ☐	
Osteopath	Yes ☐ No ☐	$	Yes ☐ No ☐	
Physiotherapist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Massage Therapist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Psychologist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Speech Therapist	Yes ☐ No ☐	$	Yes ☐ No ☐	

Note: *X-ray examinations provided by a licensed chiropractor, osteopath, chiropodist and podiatrist are eligible and included in the benefit maximum.* ***See modifications if X-rays do not apply to all practitioners***

Optional Practitioners to include:

Practitioner	Included	Annual Maximum	Physician's Referral Required	Modifications
Audiologist	Yes ☐ No ☐	$	Yes ☐ No ☐	
Christian Science Practitioner	Yes ☐ No ☐	$	Yes ☐ No ☐	
Dietician	Yes ☐ No ☐	$	Yes ☐ No ☐	
Homeopath (Must be combined with Naturopath)	Yes ☐ No ☐	$	Yes ☐ No ☐	
Kinesitherapist/Orthotherapist (Must be combined with Massage Therapist)	Yes ☐ No ☐	$	Yes ☐ No ☐	
Psychoanalyst (Must be combined with Psychologist)	Yes ☐ No ☐	$	Yes ☐ No ☐	
Psychiatrist (Must be combined with Psychologist)	Yes ☐ No ☐	$	Yes ☐ No ☐	
Social Worker	Yes ☐ No ☐	$	Yes ☐ No ☐	

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

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Extended Health Benefit (con't)	Standard Schedule of Benefits	Modifications
Accidental Dental Yes ☐ No ☐Charges for the services of a licensed dental provider for the repair or replacement of sound natural teeth when caused by an external force or blow to the face.	Services rendered must be completed within twelve (12) consecutive months of the date of the accident. *Pre-approval by ClaimSecure is required.*	
Ambulance Yes ☐ No ☐Charges for Ground Ambulance Service to the nearest Hospital or other medical facility capable of providing the required care. Emergency transportation by air, rail or water may be considered. Pre-approval by ClaimSecure is required. Limitations may apply.	Only charges for uninsured amounts will be considered.	
Convalescent Care Yes ☐ No ☐ Convalescent facility room charges provided to a covered person who is receiving active treatment or rehabilitation for a condition that will significantly improve as a result of convalescent care. *Exclusions:* Room charges for chronic care, custodial care, home for the aged, alcohol and substance abuse, mental health.	Maximum Benefit is $20 per day up to one-hundred-twenty (120) days per covered person per disability and immediately follows three (3) or more days of hospital confinement of acute care.	
Diagnostic Services Yes ☐ No ☐ Diagnostic laboratory and x-ray procedures which are defined as diagnostic testing of blood, urine or other bodily fluids and tissues and radiographic examinations performed in the covered person's province of residence are covered when coverage is not available under the provincial government plan.	- Unlimited	
Eye Exams Yes ☐ No ☐ **Note:** *Provided by a licensed ophthalmologist or optometrist.*	Maximum Benefit is one (1) eye exam per covered person to a maximum of $50 per benefit period	
Hearing Aids Yes ☐ No ☐ The purchase of a new hearing aid(s) or repair of an existing hearing aid(s). ***Note:*** A Physician or Audiologist's referral is required for the purchase of a hearing aid. Provincial assistive device program maximums will be taken into consideration where applicable. *Exclusions*: Hearing tests, batteries and ear moulds are not covered.	Maximum Benefit is $500.00 every sixty (60) consecutive months per covered person.	

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Extended Health Benefit (con't)	Standard Schedule of Benefits	Modifications
Medical Equipment/Supplies Yes ☐ No ☐ The medical equipment and supplies listed below are covered when prescribed by a physician. Such equipment must be required for therapeutic use. Coverage is for supplies and equipment available on a rental basis, however, the cost of purchase for the equipment or supply may be considered on a case-by-case basis. Pre-approval may be required for specific medical equipment. Provincial Assistive Device program maximums will be taken into consideration where applicable. **Exclusions:** The medical equipment benefit does not include charges for the maintenance of medical equipment rented or purchased. Rental costs may not exceed the purchase price.		
Breathing Equipment Yes ☐ No ☐ • Continuous Positive Airway Pressure Machine (CPAP & APAP) **(Supplies excluded)**	- Maximum Benefit one (1) per lifetime per covered person.	
• Intermittent Positive Pressure Breathing Machine (IPPB) **(Supplies excluded)**	- Maximum Benefit one (1) per lifetime per covered person.	
• Apnea Monitors for respiratory dysrhythmias	- Unlimited	
• Mist Tents and Nebulizers	- Unlimited	
• Oxygen (including cylinders and concentrators) and the equipment needed for its administration	- Unlimited	
• Tracheostoma tubes	- Unlimited	
Orthopaedic Equipment Yes ☐ No ☐ • Braces ***Note:*** Braces are wearable, orthopaedic appliances and must be made of rigid or semi-rigid material such as metal or hard plastic to hold parts of the body of the correct position. *Exclusions*: Elastic supports and foot orthotics and dental braces are not considered as an orthopaedic appliance.	- Unlimited	
• Splints: including splints attached to a brace *Exclusions*: Intra-oral splints are not covered.	- Unlimited	
• Casts	- Unlimited	
• Cervical Collars	- Unlimited	
Prosthetic Equipment Yes ☐ No ☐ • External Breast Prosthesis ***Note:*** Required because of a total or radical mastectomy	Maximum Benefit is (1) per breast per benefit period per covered person.	
• Standard Artificial Limbs *Exclusions*: Myoelectric limbs.	- Unlimited	
• Artificial Eyes including repair and replacement	- Unlimited	
• Stump Socks	- Unlimited	
• Shoulder Harnesses	- Unlimited	

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Extended Health Benefit (con't)	Standard Schedule of Benefits	Modifications
Mobility Aids Yes ☐ No ☐ • Standard Wheelchair, or where medically required electric wheelchairs	Maximum Benefit is $3,000.00 every sixty (60) consecutive months per covered person. Pre-approval by ClaimSecure is required.	
• Canes	- Unlimited	
• Crutches	- Unlimited	
• Walkers	- Unlimited	
Other Medical Equipment Yes ☐ No ☐ • Blood Glucose Monitoring Machines	Maximum Benefit is one every 48 months per covered person.	
• Insulin Infusion Sets & Reservoirs Sets *Exclusion:* Insulin Infusion Pump	- Unlimited	
• Intra-uterine Contraceptive Devices *Inclusion:* Mirena *Note:* Must be inserted by a doctor	- Unlimited	
• Standard Hospital Beds *Exclusion:* Electric hospital beds	- Unlimited	
• Support Hose and Compression Stockings (*Note*: coverage only for compression factor greater than 20 MM/HG)	Maximum Benefit of 4 pairs per benefit period per covered person.	
• Aerochambers *(Note:* covered only for children under the age of seven)	-Unlimited	
• Surgical Brassieres (following a mastectomy)	Maximum Benefit of 2 per benefit period per covered person.	
• Transcutaneous Nerve Stimulators for the control of chronic pain (Tens machine)	Maximum Benefit of $700.00 per lifetime per covered person.	
• Wigs ***Note:*** For cancer patients undergoing chemotherapy	Maximum Benefit of $200.00 per lifetime per covered person.	
• Bed Rails	-Unlimited	
• Colostomy and Ileostomy Supplies	-Unlimited	
• Custom-Made Burn Garments	-Unlimited	
• Custom-Made Pressure Supports for lymphedema	-Unlimited	
• Head Halters	-Unlimited	
• Traction Apparatus	-Unlimited	
• Trapeze Bars	-Unlimited	
• Urethral Catheters	-Unlimited	

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

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Extended Health Benefit (con't)	Standard Schedule of Benefits	Modifications
Orthotics Yes ☐ No ☐ **Custom Moulded Orthotics** Physician's or Chiropodist/Podiatrist's referral required and must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (C PED (c) or C PED (MC)), Podiatrist (DPM) or Chiropodist (D CH or D Pd M).	Maximum Benefit of $400.00 per benefit period per covered person	
Custom Made Orthopaedic Shoes Yes ☐ No ☐ Physician's or Chiropodist/Podiatrist's referral required and must be dispensed by an Orthotist (CO or CPO(c)), Pedorthist (C PED (c) or C PED (MC)), Podiatrist (DPM) or Chiropodist (D CH or D Pd M).	Maximum Benefit of $400.00 every thirty-six (36) consecutive months per covered person	
Off the Shelf Orthopaedic Shoes and Orthopaedic Modifications Yes ☐ No ☐ Orthopaedic Shoe (s) or the permanent modification of a regular shoe. Modifications may include sole buildups, lifts, wedges, steel plates, caliper plates, stirrups to accommodate braces and self-adhesive closures. *Exclusions:* The Orthopaedic Shoe Benefit does not include shoes purchased only to accommodate orthotics or comfortable walking shoes such as Berkenstock, Nike, Brooks, Rockport, etc.	Combined Maximum Benefit $150.00 per benefit period per covered person.	
Hospital Care Yes ☐ No ☐ The hospital stay must be for acute care as a result of illness, injury and/or pregnancy. Room charges provided to a covered person in a public, licensed hospital. *Exclusions:* Room charges for outpatient care, day surgery, private hospital, nursing home, chronic care facilities, home for the aged and rest home	☐ Semi-Private ☐ Private (includes Semi-Private) **Daily Maximum:** ☐ Unlimited ☐ $ _____	
Private Duty Nursing Yes ☐ No ☐ Services rendered must require the skill of a Registered Nurse, Licensed Practical Nurse or Registered Nursing Assistant. The Nursing Provider may not be a resident of the Participant's family. Services must be determined to be medically necessary and must be provided in a Participant's home. Services rendered must require the skill of a Registered Nurse, Licensed Practical Nurse or Registered Nursing Assistant. Services must be pre-approved by ClaimSecure with such approval being subject to periodic reassessment.	Maximum Benefit $10,000.00 per benefit year per covered person.	
Special Vision Benefit After Surgery Yes ☐ No ☐ An initial pair of frames and one (1) corrective lens, contact lens or prosthetic lens after cataract surgery ***Note:*** This benefit is ***in lieu*** of the frames and prescription lenses, or prescription contact lenses benefit.	Maximum Benefit is one (1) per eye per lifetime per covered person.	

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VISION CARE SERVICES Yes ☐ No ☐ Frames and prescription lenses, prescription sunglasses or prescription contact lenses when dispensed by a licensed optometrist, optician or ophthalmologist. *Exclusions:* • Refractions required by a Client, government body or other third party. • Safety glasses or safety goggles. • Replacement of lost, stolen or broken lenses or frames. • Duplicate or spare eye glasses. • Intra-ocular lens implants. • Non-prescription sunglasses. • Laser Eye Surgery	Maximum Benefit is: $200.00 every twenty-four (24) consecutive months per covered person from last date of purchase. .	

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

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General Limitations and Exclusions for Extended Health Benefits

In addition to the limitations and exclusions of this benefit Plan, and those limitations and exclusions contained in the description of the benefits, the Extended Health Benefits do not cover services, supplies or equipment that are primarily intended to facilitate:

- Expenses that private insurers are not permitted to cover by law
- Services or supplies to person is entitled to without charge by law or for which a charge is made only because the person has insurance
- Service and supplies that do not represent reasonable treatment
- Services or supplies associated with services rendered for cosmetic reasons, exercise, weight loss, physical fitness or sports, environmental or atmospheric control in the home or workplace
- The diagnosis or treatment of infertility
- Services or supplies associated with covered items, unless specifically listed as a covered expense
- Extra medical supplies that function as spares or alternates
- Services or supplies received outside Canada except as provided under the out-of country emergency care
- Services covered by any Workplace Safety an Insurance board unless prohibited by any Government legislation
- Services and supplies not shown in the included list of benefits
- Expenses for services, treatment of supplies, which are considered experimental in nature
- Any claim expenses or service provided by an immediate family member are not eligible for coverage/payment.
- Health care services or supplies required as a result of war, terrorism, rebellion or hostilities or any kind, whether or not the covered person is a participant
- Health care services or supplies required as a result of participation in a riot or civil disturbance
- Health care services or supplies due to intentional self inflicted injury

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15. Dental Benefit Yes ☐ No ☐

Indicate Division→						
Indicate Unit (Class)→						
a) Benefit Period: Indicate **CAL** for Calendar Year or **POL** for Policy Year. Where POL is indicated, please state period i.e. June 1						
b) Reimbursement Method: Indicate **EDI** or **Paper**						
c) Annual Deductible	Yes ☐	No ☐				
If applicable: ☐ Single ☐ Family ☐ Calendar Year ☐ Policy Year			$	$	$	$
Do you wish to waive the deductible for the balance of the first year?						
d) Recall Frequency : ( ) mths						
e) Fee Guide Year: choose one of the following: Fixed (indicate "F" and year) Current Year (indicate "C") Lagging Fee Schedule (indicate "L" and #yrs)						
f) Specialist Fees Covered	Yes ☐	No ☐				
g) Co-insurance (Plan pays)						
Level 1: Basic Dental:			%	%	%	%
Level 2: Perio & Endo:			%	%	%	%
Level 3: Major Restorative:			%	%	%	%
Level 4: Orthodontics:			%	%	%	%
h) Annual $ Maximum: **Level 1 Basic**			$	$	$	$
i) Annual $ Maximum: **Level 2 Endo & Perio**			$	$	$	$
j) Annual $ Maximum: **Level 1 & 2 Combined**			$	$	$	$
k) Annual $ Maximum: **Level 3 Major Restorative**			$	$	$	$
l) Annual $ Maximum: **Level 1, 2, & 3 Combined**			$	$	$	$
m) Annual $ Maximum: **Other**			$	$	$	$
n) Lifetime $ Maximum: **Level 4 Orthodontics**	Yes ☐	No ☐	$	$	$	$
o) Age Max. for Orthodontic If yes indicate maximum age	Yes ☐	No ☐				
Overall Lifetime $ Maximum If yes indicate amount $	Yes ☐	No ☐				
p) Benefit Maximum Age						
q) Dependent Maximum Age						
r) Student Maximum Age						
Survivor Benefit ☐ standard 24 months ☐ other						
s) Lab fees are calculated at 50% of the eligible procedure cost (subject to co-pay).			Yes ☐ **or** indicate percentage %			

Level 1 Basic Dental Yes ☐ No ☐

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Includes Diagnostic, Preventive, Minor Restorative, Minor Oral Surgical, Maintenance only of Prosthetic Denture and Denture Maintenance, and Adjunctive Services.	
Diagnostic Services (services to diagnose a dental condition) **Standard Schedule of Benefits**	**Modifications**
Complete examination one (1) complete examination every thirty-six (36) consecutive months	_____ Every _____ Months
Recall examination one (1) recall examination	_____ Every _____ Months
Specific examination two (2) specific examinations every twelve (12) consecutive months	_____ Every _____ Months
Emergency examination two (2) emergency examinations every twelve (12) consecutive months	_____ Every _____ Months
Complete series of radiographs or panoramic radiograph one (1) complete series or panoramic radiograph every thirty-six (36) consecutive months	_____ Every _____ Months
Bite-wing radiographs one every twelve (12) consecutive months	_____ Every _____ Months
Bacteriological tests/analyses	
Histopathological tests/analyses	
Microbiological tests/analyses	
Occlusal radiographs	
Periapical radiographs	
Preventive Services (services to prevent future dental problems) **Standard Schedule of Benefits**	**Modifications**
Fluoride one (1) fluoride treatment every recall examination period	_____ Every _____ Months Children under ( ) years of age
Oral hygiene instruction one (1) occurrence per lifetime	_____ Every _____ Months
Polishing one (1) unit of polishing every recall examination period	_____ Every _____ Months
Scaling/root planing four (4) units of time per benefit period	☐ ( ) units based on: ☐ Calendar year ☐ Policy year ☐ 12 Consecutive months
Interproximal disking	
Pit & fissure sealants	Children under ( ) years of age
Space maintainers & maintenance of space maintainers	Children under ( ) years of age

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

Level 1 Basic Dental (con't)

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Minor Restorative (services to repair teeth) **Standard Schedule of Benefits**	**Modifications**
Amalgam restorations. *Limitation:* non-bonded amalgam restorations. Bonded amalgam restorations are paid up to the cost of non-bonded amalgam restorations.	
Prefabricated restorations (prefabricated crowns) *Limitation:* primary Teeth only	
Tooth coloured restorations - Coverage for white fillings on molar teeth	Yes ☒ No ☐
Caries/trauma/pain control	
Prefabricated posts	
Retentive pins	
Minor Oral Surgical (oral surgery services) **Standard Schedule of Benefits**	**Modifications**
Alveoloplasty – simple	
Antral surgery	
Extractions & residual root removal	
Fractures	
Frenectomy	
Hemorrhage control	
Surgical excision	
Surgical exposure	
Surgical incision	
Treatment of salivary glands	
Vestibuloplasty	
Crown / Bridge / Denture Maintenance (services for the repair of prosthetic appliances) **Standard Schedule of Benefits**	**Modifications**
Denture rebase *Limitation:* one (1) per arch every thirty-six (36) consecutive months	_____ Every _____ Months
Denture reline *Limitation:* one (1) per arch every thirty-six (36) consecutive months	_____ Every _____ Months
Denture repair	
Recementation of crowns/bridgework	
Repair of crowns/bridgework	
Adjunctive services (services not classified elsewhere) **Standard Schedule of Benefits**	**Modifications**
Deep sedation	
General anaesthesia	
Nitrous oxide	
Nitrous oxide with oral sedation	
Parenteral conscious sedation	
Therapeutic injections	

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

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Level 2 Endodontics and Periodontics Yes ☐ No ☐

Endodontic services (services to treat the pulp chamber of the tooth) **Standard Schedule of Benefits**	**Modifications**
Routine root canal therapy *Limitation:* Complicated root canal therapy reduced to cost of routine root canal therapy. Retreatment of root canal is covered only if at least thirty-six (36) consecutive months have elapsed from the date of the initial root canal therapy. No coverage for primary teeth.	_____ Every _____ Months
Apexification	
Apicoectomy	
Bleaching of endodontically treated teeth	
Hemisection	
Intentional removal and implantation	
Isolation of endodontic tooth	
Open & drain	
Pulpectomy	
Pulpotomy	
Retrofilling	
Root amputation	
Periodontic services (services to treat the tissue supporting the teeth) **Standard Schedule of Benefits**	**Modifications**
Periodontal appliances and maintenance *Limitation:* one (1) appliance per arch every thirty-six (36) consecutive months	_____ Every _____ Months
Management of oral disease	
Occlusal equilibration	
Periodontal abscess or periocoronitis	
Periodontal surgery – flap approach – osteoplasty	
Periodontal surgery – flap approach – osseous defect	
Periodontal surgery – gingival curettage	
Periodontal surgery – gingivoplasty	
Periodontal surgery – gingivectomy	
Periodontal surgery – grafts – soft tissue	
Proximal wedge	

Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)

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Level 3 Major Restorative **Yes** ☐ **No** ☐ Includes Major Restorative and Major Oral Surgical Services	
Missing Tooth exclusion applicable	Yes ☐ No ☐ (The initial placement of dentures and bridgework may not be covered if at least one tooth to be replaced is not extracted while the member was covered by the employer's dental plan)
Replacement frequency **60 months** for inlays, onlays, crowns, bridgework and dentures	_____ Every _____ Months

Major Restorative- Standard Schedule of Benefits	**Modifications**
Inlays/Onlays/Crowns	
Inlays – metal, composite, porcelain	
Onlays – metal composite, porcelain	
Prosthodontic examinations	
Acrylic crowns	
Porcelain/ceramic crowns	
¾ porcelain/ceramic crowns	
Cast metal crowns	
¾ cast metal crowns	
Gold foil restorations	
Cores – amalgam and tooth coloured	
Equilibration casts	
Posts, cores and posts & cores	
Retentive pins for inlays, onlays & crowns	
Dentures	**Modifications**
Complete dentures *Limitation:* standard complete dentures	
Cast partial dentures including partial dentures with clasps and/or rests	
Overdentures and complicated dentures reduced to the cost of standard dentures	
Partial acrylic dentures including partial dentures with clasps and/or rests	
Bridgework	**Modifications**
Cast metal pontics	
Porcelain/ceramic pontics	
Acrylic retainers.	
Porcelain/ceramic retainers	
Cast metal retainers	
¾ cast metal retainers	
Metal, composite and porcelain inlay retainers	
Metal, composite and porcelain onlay retainers	
Retentive pins for inlay/onlay retainers	

Level 3 Major Restorative (con't)	
Major Oral Surgery **Standard Schedule of Benefits**	**Modifications**
Alveoloplasty (not performed in conjunction with extractions)	

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Crown lengthening	
Mandibulectomy	
Maxillectomy	
Reconstruction	
Remodelling floor of mouth	
Sequestrectomy	
Surgical movement of teeth	
Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)	

Level 4 Orthodontics **Yes** ☐ **No** ☐

Standard Schedule of Benefits	**Modifications**
Cephalometric radiographs	
Diagnostic photographs	
Enucleation	
Full orthodontic treatment	
Hand & wrist radiographs	
Interpretation from other source	
Monthly payments	
Oral surgery performed in conjunction with orthodontics (These services will be evaluated on a case by case basis)	
Orthodontic examinations	
Orthodontic casts	
Surgical exposure	
Tracing & interpretation	
Plan Modifications (additional information) – to indicate more specifics to modifications, divisions/units (classes)	

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General Limitations and Exclusions for Dental Benefits

In addition to the limitations and exclusions of this Benefit Plan, and those limitations and exclusions contained in the description of the benefits, the dental benefits do not cover the following:

- Charges for services provided for cosmetic reasons only, except for orthodontic services when such services are included in the orthodontic services benefit in the schedule of dental benefits and orthodontic services are included under this benefit plan
- Charges for missed or cancelled appointments, completion of forms, communications, or any other non-treatment services
- Charges for services or supplies that are not necessary dental services or do not meet accepted standards of dental practice.
- Under this benefit charges which are covered under any other benefit in this benefit plan.
- Professional fees for an anesthetist
- Replacement of lost, stolen or broken prostheses or appliances
- Protective appliances for athletic purposes
- Implant and any dental service associated with implants
- Services covered by any Workplace Safety an Insurance board unless prohibited by any Government legislation
- Services and supplies not shown in the included list of benefits
- Any claim expenses or service provided by an immediate family member are not eligible for coverage/payment.
- Dental services or supplies required as a result of war, terrorism, rebellion or hostilities or any kind, whether or not the covered person is a participant
- Dental services or supplies required as a result of participation in a riot or civil disturbance
- Dental services or supplies due to intentional self inflicted injury.

16) Health Spending Account ☐ Yes ☐ No

Indicate Division→					
Indicate Unit (Class)→					
a) Benefit Period: Indicate **CAL** for Calendar Year or **POL** for Policy Year. Where POL is indicated, please state period. Ie. June 1					
b) Calculation ☐ Manual ☐ Formula – indicate amount					
c) Frequency ☐ Annual ☐ Lifetime					
d) Pro-rating for initial enrolment – indicate Yes or No					
e) Pro-rating for new employees – indicate Yes or No					
f) Prior Period Grace – indicate number of days (30 or 60)					
g) Termination Age					
h) Carry forward of Credit Dollars – indicate Yes or No					

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17) Out Of Country ☐ **Yes** ☐ **No**

	Indicate Division→					
	Indicate Unit (Class)→					
a) Trip Duration For Active Employees under age 70 (Indicate number of days)						
Trip Duration For Active Employees age 70 and over and All Retirees (Indicate 30 or 60 days)						
b) Stabilization Period for Retirees and Active Employees 70 and over (Indicate 3 or 6 months)						
c) Benefit Maximum Age						
d) Dependent Maximum Age						
e) Student Maximum Age						
f) Unit Premium Rate	Single *under* age 70	$	$	$	$	$
	Family *under* age 70	$	$	$	$	$
	Single 70 and over or Retired	$	$	$	$	$
	Family 70 and over or Retired	$	$	$	$	$

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18) Web Eligibility, Claims Entry/Query, Online Reporting and Client Downloads

(Internet Browser: Internet Explorer 7.x {with MSXML 4.0 or greater} or Firefox 3.0.x)

Web Eligibility	☐ Yes ☐ No
Claims Entry/Query	☐ Yes ☐ No
Client Download	☐ Yes ☐ No
Online Reporting	☐ Yes ☐ No
HR Second Opinion	☐ Yes ☐ No

Web Eligibility. Claims Entry/Query		
Client Name	_____	I.E.: ClaimSecure
Client ID	_____	(8 Alphanumeric Characters – no spaces)

ELIGIBILITY PRIVILEGES		GROUP	DIVISIONS	UNITS
☐	Eligibility Entry			
☐	Eligibility Query			
☐	HR Second Opinion			

The following privileges are only available for Insurers, Third Party Administrators, Unions, Associations and/or Trustees.

CLAIMS ENTRY/QUERY PRIVILEGES		GROUP	DIVISIONS	UNITS
☐	Drug Claims Entry			
☐	Drug Claims Query			
☐	Dental Claims Entry			
☐	Dental Claims Query			
☐	EHC Claims Entry			
☐	EHC Claims Query			
☐	Regular Price Query			
☐	Generic Price Query			
☐	All Benefits Query			

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GROUP #	

Web Eligibility

USER SECURITY PROFILE

(Must be completed for each individual user)

Client Name	
Client ID	

ELIGIBILITY QUERY	ELIGIBILITY ENTRY	HR SECOND OPINION	USER NAME	USER ID (Max 8 Characters)	GROUP #	DIVISION	UNIT
☐	☐	☐				☐ ALL	☐ ALL
☐	☐	☐				☐ ALL	☐ ALL
☐	☐	☐				☐ ALL	☐ ALL
☐	☐	☐				☐ ALL	☐ ALL
☐	☐	☐				☐ ALL	☐ ALL
☐	☐	☐				☐ ALL	☐ ALL

CLIENT #	
GROUP #	

Claims Entry/Query and All Benefit Query

USER SECURITY PROFILE

(Must be completed for each individual user)

The following privileges are only available for Insurers, Third Party Administrators, Unions, Associations and/or Trustees.

Client Name	____
Client ID	____

User Name	____	I.E. (Jane Smith)
User ID	____	I.E. (JSMITH) (Max 8 Alphanumeric Characters)

PRIVILEGES		GROUP	DIVISIONS	UNITS
☐	Drug Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Drug Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Dental Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Dental Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	EHC Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	EHC Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Regular Price Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Generic Price Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	All Benefit Query	____	____ ☐ **ALL**	____ ☐ **ALL**

CLIENT #	
GROUP #	

Claims Entry/Query and All Benefit Query

USER SECURITY PROFILE

(Must be completed for each individual user)

The following privileges are only available for Insurers, Third Party Administrators, Unions, Associations and/or Trustees.

Client Name	____
Client ID	____

User Name	____	I.E. (Jane Smith)
User ID	____	I.E. (JSMITH) (Max 8 Alphanumeric Characters)

PRIVILEGES		**GROUP**	**DIVISIONS**	**UNITS**
☐	Drug Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Drug Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Dental Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Dental Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	EHC Claims Entry	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	EHC Claims Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Regular Price Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	Generic Price Query	____	____ ☐ **ALL**	____ ☐ **ALL**
☐	All Benefit Query	____	____ ☐ **ALL**	____ ☐ **ALL**

CLIENT #	
GROUP #	

Claims Entry/Query and All Benefit Query

USER SECURITY PROFILE

(Must be completed for each individual user)

The following privileges are only available for Insurers, Third Party Administrators, Unions, Associations and/or Trustees.

Client Name	_____
Client ID	_____

User Name	_____	I.E. (Jane Smith)
User ID	_____	I.E. (JSMITH) (Max 8 Alphanumeric Characters)

PRIVILEGES		**GROUP**	**DIVISIONS**	**UNITS**
☐	Drug Claims Entry	_____	☐ **ALL**	☐ **ALL**
☐	Drug Claims Query	_____	☐ **ALL**	☐ **ALL**
☐	Dental Claims Entry	_____	☐ **ALL**	☐ **ALL**
☐	Dental Claims Query	_____	☐ **ALL**	☐ **ALL**
☐	EHC Claims Entry	_____	☐ **ALL**	☐ **ALL**
☐	EHC Claims Query	_____	☐ **ALL**	☐ **ALL**
☐	Regular Price Query	_____	☐ **ALL**	☐ **ALL**
☐	Generic Price Query	_____	☐ **ALL**	☐ **ALL**
☐	All Benefit Query	_____	☐ **ALL**	☐ **ALL**

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Online Reporting					
Client/Broker/TPA Name					
Client Number					
Group Number					
Client ID	_____ (7 and 12 characters)		☐ New Client or ☐ Existing Client		
Language	☐ English ☐ French				
☐ Drug	☐ Dental	☐ EHB	☐ Other Specify:		
☐ By Group	☐ By Client	☐ By Division	☐ Other Specify:		
Include Certificate Info ☐	Can see member names and certificates (Privacy document on file)				

Client Download Claims Extract		
Client Name		I.E.: ClaimSecure
Client ID		(8 Alphanumeric Characters – no spaces)
Client Number		
Group Number		Only required if there are groups to be excluded from the Insurance Company

Client Download Download Options			
☐ Drug	☐ EHB	☐ Dental	
Secure Online File Transfer Method	Yes ☐ No ☐		
E-mail Destination			

19) Additional Comments:

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20)Schedule of Fees

In consideration for the services to be provided by ClaimSecure, ("the payor") shall pay to ClaimSecure the fees ("the fees") at the times and in the manner provided for herein:

Fee Period From: _____, 20_____ to _____, 20 _____

Services	Fee and Additional Charges (where applicable)
Claims Processing:	
Drug claims processing	per ☐paid or ☐submitted EDI claim per ☐paid or ☐submitted paper claim
Extended Health Benefit claims processing • Hospital	per ☐paid or ☐submitted claim
• Major Medical	per ☐paid or ☐submitted claim
• Vision	per ☐paid or ☐submitted claim
Dental claims processing	per ☐paid or ☐submitted EDI claim per ☐paid or ☐submitted paper claim
Health Spending Account	per ☐paid or ☐submitted claim
Plan Administration:	
Reporting • Standard reports	Included
• Enhanced reports	Initial $950, $550 additional
• Customized report	Fee for Service Basis
Clinical Services:	
• Formulary Management	per EDI claim
• Special Authorization	$ per review
• Employee Health Education	Fee for Service Basis
• Audit	Fee for Service Basis

Deposits

The Payor agrees to pay ClaimSecure an amount to be calculated in respect of deposits (Claim Deposit). The Claim Deposit will be paid contemporaneously with the execution and delivery of this Agreement and will be credited by

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ClaimSecure to the Payor. The Claim Deposit must be paid to ClaimSecure by cheque. The calculation of the Claim Deposit is based on the number of Members and ClaimSecure's assessment of the required amount including administrative fees and taxes. On the first anniversary date of this Agreement, the amount of the Claim Deposit may be recalculated based on the actual claims experience.

DEPOSIT TYPE:		
☐ Straight ASO (IBNR)	☐ Budgeted ASO (if yes, complete # 2)	
BUDGETED ASO AUTHORIZED BANK DEDUCTIONS:		
Bank Name:		
Bank Address:		
Bank Telephone Number		
Bank Contact:		
Bank Account Number:		
Bank Transit Number:		
Bank Number:		
DEPOSIT REQUIREMENT: $		
INVOICING INFORMATION:		
Primary Invoice	☐ Client	☐ Consultant/Broker/TPA
Name		
Street	Unit/Suite	
City	Province/State	
Postal/ZIP Code	Country	
Telephone	Fax	
Contact	Title	
Contact E-mail Address		
Client Tax Status	Taxable	Exempt
PST	☐	☐
Premium Tax	☐	☐
GST	☐	☐

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Attach proof of exemption from tax where applicable		
a) Separate Invoices (Additional Fee Applies)		
Is a separate invoice required (for mailing to one or more Divisional/Unit Addresses)		
Yes ☐	No ☐	If Yes, please provide details below:
Name		
Street		Unit/Suite
City		Province/State
Postal/ZIP Code		Country
Telephone		Fax
Contact		Title
Contact E-mail Address		

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Declarations and Signatures

The Contracted Party and the Payor (if a different party) hereby declare(s) that, to the best of their knowledge, the statements and answers contained above are full, complete and true as of the date hereof and agrees that:

1. Such statements and answers shall constitute the Application for and form part of the Contract;
2. The Contract will not become effective until this Application has been approved by ClaimSecure;
3. This Agreement and the ClaimSecure Services to be provided pursuant to this Agreement do not constitute a contract for insurance or risk loss, and ClaimSecure is not acting as an insurer or indemnifier for any such benefits and services; and
4. The parties hereto acknowledge that:
   - the implementation of the Benefit Plan and the Master Application may require interpretation and, in some cases, may be subject to more than one interpretation;
   - ClaimSecure has the authority to interpret the provisions of the Benefit Plan and the Master Application; and
   - any interpretation adopted by ClaimSecure in good faith and in a reasonable manner is binding.

Any delay or failure by either party hereto in performance hereunder shall be excused if and only to the extent that such delays or failures are caused by occurrences beyond such party's control, including acts of God, decrees or restraints of governments, strikes or other labour disturbances, war, sabotage, and any other cause or causes, whether similar or dissimilar to those already specified, which cannot be controlled by such party; provided that the party seeking to excuse its performance shall promptly notify the other party of the cause therefor, such performance shall be so excused during the inability of the party to perform but for no longer period, and the cause thereof shall be remedied so far as possible with all reasonable dispatch.

Except as otherwise expressly provided herein, any dispute, difference or question arising between the parties concerning the construction, meaning, effect or implementation of this Agreement or any part hereof will be settled by a single arbitrator mutually agreed on by the parties or failing agreement, an arbitrator appointed pursuant to the *Arbitration's Act* (Ontario).

From time to time ClaimSecure and the Contracted Party will at their own expense, execute and deliver such additional documents and other assurances as may be reasonably required to carry out the intent of this Agreement.

Except as specifically provided herein, no party may assign any of its rights or benefits under this Agreement to any person without the prior written consent of the other party or parties hereto.

If there occurs any Change in Law which materially alters the rights or obligations of either party under this Agreement, the parties shall equitably adjust the terms of this Agreement to take into account such Change in Law. If the parties are unable to agree upon an equitable adjustment within sixty (60) days after either

party notifies the other of such a Change in Law, this Agreement shall terminate.

Dated at **[Location]**this **[Date]**day of **[Month]**, **[Year]**.

Payor:

Per Authorized Signatory

Contracted Party (if different from Payor):

Per Authorized Signatory