JONES DESLAURIERS BLEVINS	GROUP BENEFITS PLAN FOR INDIVIDUAL CLIENTS OF THE ***JONES DesLauriers Blevins***

INTRODUCTION: **JONES** DesLauriers Blevins is pleased to announce the introduction of the Group Optional Life Insurance Plan for individual members and their member partners. The program is for participating member of **JONES** DesLauriers Blevins and is available to you and your spouse. The plan is arranged through Unistar Special Risks Inc., marketed and administered by **JONES** DesLauriers Blevins, both of whom are experienced in the members' group market.

GROUP BENEFITS PROVIDED: Benefits provided through the **JONES** DesLauriers Blevins program include the following coverage and insurers:

Benefits: Group Optional Life (Western Life)

Monthly Costs: Age banded as indicated on the following application

ELIGIBILITY: If you elect to participate, you must be a registered with **JONES** DesLauriers Blevins.

GROUP BENEFIT PLAN SUMMARY: The following summary outlines the benefits provided by this plan. Additional benefits provisions are outlined in complete detail in the benefit booklet that you receive upon enrollment in the plan.

BENEFIT	COVERAGE SUMMARY
Group Optional Life Insurance	• Flat amount of $25,000 of Group Optional Life Insurance • Waiver of Premium included if you are totally disabled following the 180 day qualifying period • Benefit terminates at age 70 • No medical questions will be asked

MONTHLY COST: These costs are guaranteed until December 31, 2017 at which time the plan will renew. Rates will not change unless the pool rates of the insurer change at a future date, plan experience dictates a change or an individual has a change in age band.

PLAN ENROLMENT: To enroll in this plan, you are required to complete the attached enrollment form. We will also require a VOID cheque for the account from which you want deductions to be withdrawn. Your monthly premium will be deducted on the 15th of each month.

The following EXCLUSIONS may apply to the life insurance product:

PRE-EXISTING EXCLUSION: No Life Insurance benefit shall be payable if, twenty-four (24) months immediately prior to the Effective Date of the Individual Insurance, the Insured Member was attended to or received medical treatment, consultation, care or services by a Physician, including diagnostic measure for any symptom or medical problem which leads to the Insured Member's death unless the death of the Insured Member occurs later than twenty-four (24) consecutive months from the Effective Date of Individual Insurance under this policy. The Insurer will refund the premiums collected for this Insured Member for the life insurance coverage in lieu of paying the life insurance benefit.

SUICIDE: No Life Insurance benefit shall be payable if an Insured Member commits suicide, whether sane or insane, and has been insured for less than twenty-four (24) months by the life insurance protection under this policy. The Insurer will refund the premiums collected for this Insured Member for the life insurance coverage in lieu of paying the life insurance benefit.

QUESTIONS: www.jdbgroup.ca

Toll Free Phone: 1.855.532.4768
Fax: 1.705.721.0352

This package is provided solely for the purpose of outlining the JONES DesLauriers Blevins **Optional Life Insurance Plan. All rights with respect to your benefits as a member of this plan will be governed by the Group Optional Life Insurance Policy issued to JONES** DesLauriers Blevins

FOR INDIVIDUAL CLIENTS OF THE

JONES DesLauriers Blevins

APPLICATION FOR GROUP COVERAGE

Please complete and return the ORIGINAL Signed Copies to **JONES** DesLauriers Blevins, 30 Quarry Ridge Road | Barrie, ON | L4M 7G1

1. Member Information (PLEASE PRINT)

First Name(s)		Last Name	
Spouse if applying requires separate application	Name of company		Number of Employees
Your Address (Including Apartment/Unit Number)			
City/Town	Province/Territory	Postal Code	Phone No. ( ) -
Email Address (for admin purposes)			
Date of Birth (MM/DD/YYYY) ______/______/______	☐ Male ☐ Female	Annual Earnings $______________________________	

2. Current Age & Premium For Compulsory Benefits (No medical questions will be asked) h

Age Band	❑ **Under 40**	❑ **Age 40 – 49**	❑ **Age 50 – 59**	❑ **Age 60 - 69**
Monthly Life Premium	❑ **Non-Smoker $2.65** ❑ **Smoker $3.93**	❑ **Non-Smoker $5.25** ❑ **Smoker $9.53**	❑ **Non-Smoker $15.10** ❑ **Smoker $25.60**	❑ **Non-Smoker $39.40** ❑ **Smoker $60.75**

3. Beneficiary Designation: To be completed to designate a beneficiary for your Life benefits. The original copy of this form will be required for a Death claim. (PLEASE PRINT CLEARLY IN INK AND INITIAL ANY SCRATCH OUTS OR WHITE-OUTS)

Beneficiary's Name(s)	**DOB (MM/DD/YYYY)**	**% Allocated**	**Relationship to Member**
(Last name) (First name) (Initial)			

Trustee Name (Required if beneficiary is a minor under age 18) Name Relationship

I hereby make the above beneficiary designation: ❑ **Revocable** ❑ **Irrevocable**

4. Monthly Premiums Payment: I would like to pay my monthly premiums via:

☐ **Automatic Bank Withdrawal** ***(Please include a blank personal cheque marked "VOID", along with a signed Authorization Agreement (attached))***

5. Consent and Signature

I hereby apply for coverage under the Group. I further authorize the deduction and remittance of premiums from my bank account by JONES DesLauriers Blevins**, as I have indicated above, for my contribution toward the cost of these benefits. I further consent to disclosure, collection, and use of any information required to administer the plan.**

X ______________________________ ______________________________

Signature of Applicant **Date (MMM/DD/YYYY)**

X ______________________________ ______________________________

Signature of Spouse (if spousal coverage selected) **Date (MMM/DD/YYYY)**

PRE-AUTHORIZED PAYMENT AUTHORIZATION

Name (Company or Individual): (as it appears on your VOID Cheque)		**Phone #:**	
Address:			

I (we) authorize Adminplex Resource Services Inc. to process a debit, in paper, electronic or other form on the 15th day of each month. If the 15th occurs on the weekend (Saturday/Sunday) the debit will be process on the preceding Friday.

I (we) acknowledge that I (we) have read, understood and accepted all the provisions contained in the Terms and Conditions below of the Pre-Authorized Payment Authorization and that I (we) have received a copy.

Names(s) of authorized Signing Officer (s)	Signature(s) of Authorized Signing Officer(s)	Date

NOTE: Attach your personal (or company) blank cheque marked "void"

TERMS AND CONDITIONS

- I (We) acknowledge that this Authorization is provided for the benefit of the Payee and (Processing Institution) and is provided in consideration of (Processing Institution) agreeing to process debits against my account in accordance with the Rules of the Canadian Payments Association.
- I (We) warrant and guarantee that all persons whose signatures are required to sign on this account have signed this agreement below.
- I (We) hereby authorize Adminplex Resource Services Inc. to draw on Payor **account number** _________**See Attached**___________________ with (Processing Institution), for the following purpose paying **Monthly Employee Benefit Premiums**.
- This authorization may be cancelled at any time upon 15 days notice by Payee. I (We) acknowledge that, in order to revoke this authorization, I (We) must provide notice of revocation to Adminplex Resource Services Inc.. I (We) may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca
- I (We) acknowledge that provision and delivery of this authorization to (Name of Payee constitutes delivery by Payor to (Processing Institution). Any delivery of this authorization to you constitutes delivery by Payor.
- The Payor and Payee agree to waive the pre-notification requirement set out in Section 11 of Appendix II of rule H1 of the Canadian Payments Association
- I (We) undertake to inform Adminplex Resource Services Inc., in writing, of any change in the account information provided in this authorization prior to the next due date of the PAD.
- The account that Adminplex Resource Services Inc. is authorized to draw upon is indicated in the accompanying authorization. A specimen cheque for this account has been marked "VOID" and attached hereto.
- I (We) acknowledge that (Processing institution) is not required to verify that a PAD has been issued in accordance with the particulars of the Payor's Authorization including, but not limited to, the amount.
- I (We) acknowledge that (Processing Institution) is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by Adminplex Resource Services Inc. as a condition to honouring a PAD issued or caused to be issued by Adminplex Resource Services Inc. on Payor account.
- Revocation of this authorization does not terminate any contract for goods or services that exists between Payor and Adminplex Resource Services Inc.. The Payor's Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
- A PAD may be disputed by a Payor under the following conditions: (1) the PAD was not drawn in accordance with the Payor's Authorization; or
  (2) the authorization was revoked; or
  (3) pre-notification was not received.
- The Payor, in order to be reimbursed, acknowledges that a declaration to the effect that either (1), (2) or (3) took place, must be completed and presented to the branch of the Processing Institution holding the Payor's account up to and including 90 calendar days in the case of a personal/household PAD (or up to and including 10 business days in the case of a business PAD), after the date on which the PAD in dispute was posted to the Payor's account.
- The Payor acknowledges that a claim on the basis that the Payor's Authorization was revoked, or any other reason, is a matter to be resolved solely between the Payee and the Payor when disputing any PAD after (90 calendar days in the case of a personal/household PAD or 10 business days in the case of a business PAD).
- I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information my/our recourse rights I/We may contact my/our financial institution or visit www.cdnpay.ca.
- For more information or to amend or cancel this agreement, please contact Adminplex Resource Services Inc. Accounting Dept, 30 Quarry Ridge Road, Barrie, ON, L4M 7G1 or 1-800-565-2467.