C&C INSURANCE
CONSULTANTS

Health & Dental Benefits Plan for Alumni

A comprehensive Benefit Package designed specifically for Alumni.

This Benefit Plan is administered by RWAM Insurance Administrators Inc., and is distributed by C&C Insurance Consultants Ltd., through their Student VIP Program.

The Extended Health Care and Dental Benefits are underwritten and insured by The Co-operators Life Insurance Company. Mondial Assistance provides the Out-of-Province/Country Benefits.

Extended Health Care

The following expenses are covered* with no deductible:

Benefit	*Co-Ins.*	*Maximum*
Paydirect Prescription Drugs	*80%*	*$1,500/yr./person*
Mandatory Generic dispensing fee cap of $6.00 per prescription item		
Private Duty Nursing	*80%*	*$10,000/lifetime*
Paramedical Practitioners	*80%*	*$400/yr./practitioner*
Osteopath, Naturopath, Podiatrist, Chiropodist, Psychologist/Social Worker, Physiotherapist, Acupuncturist, Speech and/or Massage Therapist		
Chiropractor	*80%*	*$20/visit - $400/yr.*
Eye Examination	*80%*	*1 Exam/24 mths. $50/max.*
Orthopedic Shoes/Orthotics	*80%*	*$250/yr.*
Hearing Aids	*80%*	*$400/5 yrs.*
Cardiac Rehabilitation	*80%*	*$500/yr.*
Prosthetics	*80%*	*$10,000/lifetime*
Medical Supplies	*80%*	*unlimited*
Emergency Ambulance	*80%*	*unlimited*
Accidental Dental	*80%*	*$2,000/lifetime*
Anti-Smoking, Fertility Drugs & Treatments		*excluded*
Semi-Private Hospital		*excluded*

Out-of-province

If the employee or eligible dependent becomes ill or injured whie travelling, emergency hospital and medical expenses will be paid at 100%, in excess of the amount paid by the Provincial Health Insurance Plan.

This benefit is subject to a $2,000,000 maximum and does not include referral coverage. Eligible benefits are limited to a maximum of 30 days per trip, commencing with the date of departure from your province of residence. If you are hospitalized on the 30th day, benefits will extend until the date of discharge.

*All coverage subject to terms & conditions of the insurance policy

Dental Care *(optional)*

This plan will pay 80% of basic covered expenses with no annual deductible. Benefit payment is based on the current provincial fee schedule to a maximum of $1,000 per calendar year per insured.

Covered Expenses:

- *oral examinations, cleaning and polishing of teeth, but not more than once every nine (9) months*
- *fluoride applications*
- *x-rays*
- *fillings*
- *space maintainers*
- *extractions*
- *anaesthesia*
- *endodontics (root canal therapy)*
- *periodontics (treatment of soft tissue (gums) and bone supporting the teeth)*
- *repairs or relining and rebasing of dentures*

Eligibility Requirements

The Extended Health Care benefit is mandatory.

Members must complete a medical questionnaire for approval.

All members and their dependents must be insured under their Provincial Health Insurance Plan.

Pre-Authorized Debit is mandatory.

Applications & Questions

Please direct all inquires and requests for applications to:

Becky Ambrose - becky.ambrose@ccinsurance.ca

Please send all completed applications to:
C&C Insurance Consultants
6-22425 Jefferies Rd. Komoka, ON N0L 1R0

C&C INSURANCE
CONSULTANTS

Health & Dental Benefits

Rates & Additional Information

Rates

Province of Residence (at time of application)	Coverage Type	Extended Health Care & Out of Canada	Dental (Optional)
Alberta	Single Family	$79.93/month $177.94/month	$43.31/month $106.79/month
Newfoundland	Single Family	$80.27/month $178.61/month	$22.79/month $56.18/month
Atlantic Canada (excluding Newfoundland)	Single Family	$80.27/month $178.61/month	$34.55/month $84.47/month
British Columbia	Single Family	$58.82/month $126.92/month	$47.72/month $117.97/month
Ontario	Single Family	$79.93/month $177.94/month	$45.57/month $112.35/month
Manitoba/Saskatchewan	Single Family	$62.24/month $135.49/month	$29.56/month $73.03/month

Please note additional fees & taxes may apply

Additional Information

- Those who are eligible and sign up are required to complete a 12 month term on the plan, if you wish to cancel prior to this term, you will be assessed an early cancellation fee based on how many months you have remaining in your term and your usage of the plan.
- All fees are paid on a monthly basis by direct debit (mandatory) from your bank account. Appropriate provincial sales tax will be applied to the base fee.
- You must have Extended Health Care & Out of Canada coverage in order to apply for Dental Coverage.
- If you have any questions, please e-mail info@studentvip.ca or call 1-888-918-5056.
- Please mail completed applications to:

C&C Insurance Consultants Ltd.
Attn: Becky Ambrose
6-22425 Jefferies Road, RR5
Komoka, ON
N0L 1R0

RWAM Insurance Administrators Inc.

MASTER APPLICATION
STUDENT ALUMNI PLAN

CHECKLIST

Master Application
- Ensure that application is complete, signed by the applicant and their signature is witnessed
- Any changes and/or corrections should be initialed by the applicant as this document forms part of their agreement

Pre-Authorized Debit
- Pre-Authorized Debit (PAD) is mandatory for this plan. Applicant must complete & sign the attached PAD Agreement.

Enrolment Form
- Complete form in full and ensure that comparable coverage and opt-out sections are correct and signed

Binder/Deposit Cheque
- Binder/deposit cheque payable to RWAM Insurance Administrators Inc. should equal one month of estimated premium using quoted rates.
- The cheque must **not** be post-dated.

Evidence of Insurability
- Applicant must complete and submit a signed group Health Evidence form for approval

Duration of Coverage
- Coverage under this plan is to be maintained for a minimum of 12 months and if a termination request is received prior to the 12 month commitment, the applicant is subject to an early termination administration fee.

APPLICANT

Full Legal Name ______________________

Contact Person (if different from applicant) ______________________

No. and Street ______________________

Telephone ______________________

City, Province ______________________ Postal Code ______________________

Fax and/or E-mail ______________________

CURRENT BENEFITS

Current coverage elsewhere? ❑ No ❑ Yes

If 'Yes' - ______________________ Name of plan and benefits covered

______________________ Date existing coverage is to be terminated

POLICY EFFECTIVE DATE

____
Day Month Year

To avoid a period without coverage, do not terminate any existing coverage until notice has been given that RWAM Insurance Administrators Inc. has approved the coverage being applied for.

DESCRIPTION OF BENEFITS **All benefits terminate at age 70**

EXTENDED HEALTH CARE

Benefit	Co-Ins.	Maximum
Pay Direct Prescription Drugs Mandatory Generic dispensing fee cap of $6.00 per prescription item	80%	$1,500/yr./person
Anti-Smoking Drugs/Treatment (Nicotine Patch)	--	Excluded
Fertility Drugs/Treatment	--	Excluded
Private Duty Nursing	80%	$10,000-lifetime max.
Paramedical Practitioners	80%	$400/yr./practitioner Chiropractor - $20/visit
Orthopaedic Shoes	80%	$250/yr.
Orthotics	80%	$250/yr.
Hearing Aids	80%	$400 every 5 yrs.
Eye Examinations	80%	1 exam/24 months $50/exam
Accidental Dental	80%	$2,000 – lifetime max.
Medical Supplies &/or Emergency Ambulance	80%	Unlimited
Semi-Private Hospital	--	Excluded
Out-of-Canada (30 day Emergency Only)	100%	$2,000,000

DENTAL CARE (Optional)

Group Dental Plan Participation ☐ Yes ☐ No

This plan will pay 80% of basic covered expenses.
Benefit payment is based on the current Provincial Fee Schedule to a maximum of $1,000 per calendar year, per individual.

- Oral exams, cleaning & fluoride applications (not more than once every 9 months)
- X-rays
- Fillings
- Anesthesia
- Endodontics (root canal therapy)
- Periodontics (treatment of gums & other tissue of the mouth)
- Repairs, relining & rebasing of dentures

STUDENT VIP

PRE-AUTHORIZED DEBIT (P.A.D.) PLAN

- The P.A.D. withdrawal will be processed the 1st day of each month.
- ATTACH A VOID CHEQUE along with the binder/deposit cheque accompanying this application.

<< Sign Attached Pre-Authorized Debit (PAD) Agreement >>

PREMIUM SUMMARY

Single Coverage	Family Coverage
$ _______________	$ ________________

- Premiums subject to PST, if applicable
- Rates are reviewed annually with adjustments being effective January 1st regardless of the effective date.

APPLICATION TO PARTICIPATE IN THE RWAM TRUST

WHEREAS:

(a) The Applicant desires to obtain the benefits requested in this Application as eligible graduating student(s) and their eligible dependents, and hereby applies to become a Participating Member under the Retailers, Wholesalers and Manufacturers Group Insurance Trust (the “RWAM Trust”);

(b) The agreement governing the RWAM Trust (the “RWAM Trust Agreement”) provides that the trustees of the said trust, or their authorized agents, shall have the right and discretion to accept or reject applications from qualified persons to become Participating Members in the said trust from time to time;

(c) Benefits provided by licensed insurers under group insurance contracts issued to the Trustees of the RWAM Trust (the “Trustees”) include: group Extended Health Care coverage, group Dental coverage, group Life, group AD&D, and other standard and optional group insurance products;

(d) RWAM Insurance Administrators Inc. (“RWAM”) is the authorized agent of the Trustees of the RWAM Trust, and has been appointed as administrator of the RWAM Trust.

NOW THEREFORE, subject to the Applicant being accepted as a Participating Member in the RWAM Trust, THE APPLICANT ACKNOWLEDGES, UNDERTAKES AND AGREES:

1. To be bound by all the terms, provisions, conditions and limitations of the RWAM Trust Agreement and any and all insurance contracts issued to the Trustees and all lawful amendments thereto;
2. To pay, or cause to be paid, all contributions and premiums necessary to provide the benefits applied for herein, or subsequently requested, as and when required by the Trustees pursuant to the terms thereof;
3. That the only benefits provided shall be in accordance with this Application as submitted. Any changes desired by the Applicant must be requested in writing and are subject to the approval of the Trustees or their authorized agent, and shall only be effective as of the date of such approval.
4. To hold open for inspection any records in its possession or under its control relating to this Application and the benefits hereby applied for or provided hereunder, and to co-operate fully with the Trustees, RWAM and their agents in all matters regarding the benefits applied for or provided.
5. At all times, to enroll only eligible graduating students and their eligible dependents for benefit coverage.
6. To immediately inform RWAM in writing of any changes to the Contributory or Non-Contributory status of its premiums or contributions, including any changes affecting the status, for tax purposes, of any benefits provided for under this Application.
7. To provide immediate written notification to RWAM of any person who ceases meet any eligibility requirements between the date this Application is signed and the date of acceptance of this Application.

The Applicant hereby appoints RWAM Insurance Administrators Inc. to act as its agent under the RWAM Trust Agreement, to act on the Applicant’s behalf for the purposes of the said trust agreement, including, without limitation, any notice provisions or amendments thereto, save and except for any notice of default as to contributions or premiums, or any notice of termination as a Participating Member.

The Applicant hereby declares that, to the best of the Applicant’s knowledge, the statements and answers contained in this Application are full, complete and true as of the date hereof.

Subject to this Application being approved, the effective date of coverage in respect of the benefits hereby applied for shall be the Policy Effective Date indicated in this Application.

In the event any errors or omissions are discovered in this Application, RWAM is hereby authorized to amend this Application by noting the required change(s) on this Application. A copy of this amended Application shall be sent forthwith to the Applicant, and such action shall constitute acceptance of such change(s), unless the Applicant provides immediate written notice to the contrary.

An initial Premium Binder/Deposit of $ ____________________ (as per one month of estimated premium using quoted rates) is included with the Application.

Dated at ________________________________ this ________________ day of ____________________________ 20 ______
(location) (day) (month) (year)

____
Applicant (Full Legal Name)

____
Witness

____
Agent and Agency

Remit to: C & C Insurance Consultants
22425 Jefferies Road, Unit #6, R.R. #5
Komoka, ON N0L 1R0
Questions and Comments: Teri Praill 1-888-918-5056

Pre-Authorized Debit (PAD) Agreement

PAYOR INFORMATION

Name of Payor/Applicant ______________________________

Group Benefits Plan: RWAM Graduating Student Conversion Plan

PAYOR'S ACCOUNT INFORMATION

Type of Account: Savings ☐ Chequing ☐ Other ☐ ____________

Account No ____________________

Branch Transit No. __ __ __ __ __ Financial Institution No. __ __ __

Name of Financial Institution ______________________________

Address of Financial Institution ______________________________
No. & Street City

____
Province Postal Code

<<< ATTACH A VOIDED BLANK CHEQUE TO THIS FORM >>>

P.A.D. Authorization:

I authorize RWAM Insurance Administrators Inc. (RWAM) to debit the bank account identified above and/or shown on the attached void cheque for all monthly invoiced premiums in **the amount of $**______________ and any applicable taxes **on or about the 1st business day of every month**, for payment of the above named group benefits plan. I understand this authorization may be cancelled by providing written notice to RWAM at the address indicated below, at 30 days prior and no less than 10 days prior to the next scheduled debit.

I have waived the right to pre-notification of at least 10 days before my first PAD; however RWAM will send me monthly written invoices identifying any new premium amount/rate change at least 10 days before each and any change in the amount of my PAD.

My authorization may be revoked at any time in writing, subject to providing a notice period of 30 days to RWAM. To obtain a sample cancellation form or for information on my right to cancel a PAD agreement, I may contact my financial institution or visit www.cdnpay.ca.

I understand I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. If I wish to obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

These services are for (check one): ☐ Personal Use ☐ Business Use

Authorized Signature **x** ______________________________ Date ____________________

Authorized Signature **x** ______________________________ Date ____________________
If joint account, additional signature required

Remit to: C & C Insurance Consultants
22425 Jefferies Road, Unit #6, R.R. #5
Komoka, ON N0L 1R0
Questions and Comments: Teri Praill 1-888-918-5056

MASTER APPLICATION
STUDENT ALUMNI PLAN

Enrolment Form

GRADUATE

PLEASE PRINT AND COMPLETE EACH SECTION CLEARLY IN INK

Surname ______________________ First Name ______________________

Address ____
No. and Street / City/Town / Province / Postal Code

GRADUATION INFORMATION

Date of Graduation ____________ (Year / Month / Day) Degree Obtained ______________________

School of Graduation ____

GRADUATE'S DATA

NOTE: You must complete and submit a group Health Evidence form for you and any of your dependents for approval

Date of Birth ____________ (Year / Month / Day)

Gender

❍ Male ❍ Female

Marital Status:

❑ Married ❑ Divorced ❑ Separated
❑ Single ❑ Widowed ❑ Common-law*

*If Common-law, date co-habitation began: ____________ (Year / Month / Day)

❑ SINGLE, Extended Health Care
❑ SINGLE, Dental
▶

If you are eligible for family coverage, your dependents must have coverage* through your spouse

Spouse's Employer ______________________

Spouse's Group Insurance Carrier ______________________

* If the comparable coverage ceases, **advise RWAM within 31 days,** or you will be required to submit medical health evidence (at your expense) and you will be subject to a one year dental restriction

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❑ FAMILY, Extended Health Care
❑ FAMILY, Dental
▶

Indicate if you have any coverage* through your spouse:

Extended Health? ❑ No ❑ Yes Dental? ❑ No ❑ Yes

If 'Yes' - Spouse's Group Insurance Carrier**______________________

* If the comparable coverage ceases, **advise RWAM within 31 days,** or you will be required to submit medical health evidence (at your expense) and you will be subject to a one year dental restriction

** Claims must first be submitted to the primary carrier indicated above.
Any portion of the claim not reimbursed by the primary carrier, can then be sent to the secondary carrier for consideration.
Eligible dependent children's claims are reimbursed under the parent whose date of birth falls first in the calendar year.

ELIGIBLE DEPENDENTS

NOTES: A dependent child must be under age 21. A child of a common-law spouse must reside with you.
A dependent child under age 25 may be eligible *if* they are a full-time student and with proof of registration.

Surname	First Name	Relationship to Graduate	Date of Birth (yyyy/mm/dd)

AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc.(RWAM) and the insurer for the purposes of determining eligibility for group insurance coverage and benefits; and to administer benefits under this coverage. I hereby authorize my plan administrator, the authorized group agent/broker, and the insurer to exchange any relevant and necessary information for such purposes. If I am applying for coverage for my eligible dependents, I confirm I am authorized to act on their behalf for such purposes. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Graduate's Signature ✕______________________ Date ______________________

OFFICE USE ONLY

Extended Health Care	Dental	Effective Date	Group/Certificate #
☐ Single ☐ Family ☐ Nil	☐ Single ☐ Family ☐ Nil		

RWAM INSURANCE
ADMINISTRATORS INC.
49 Industrial Drive
Elmira, Ontario
N3B 3B1

1 two 3
GROUP HEALTH QUESTIONNAIRE

1. **Personal Information**

Name of Applicant ____________________ *First* *Initial* *Last* Date of Birth ___/___/___ *dd* *mm* *yyyy* Gender: ☐ M ☐ F

Address of Applicant ____________________ *# Street* *City* *Province* *Postal Code*

Name of Employer ____________________ Salary Per Month $ ____________

Telephone (Work) ___-___-___ (Home) ___-___-___ (Cel) ___-___-___

2. **Please check "Yes" or "No" to the following questions:**

		Yes	No
a)	Have you ever had, been told you have, or received treatment, medication, advice or counselling for any of the following: heart trouble, high blood pressure, ulcerative colitis, kidney disorder, diabetes, stroke, any mental or nervous disorder including stress, depression, anxiety, alcoholism, lung disorder, cancer or tumour, hepatitis, liver disorder or blood disorder, disorder of joints or limbs, including neck and back pain?	☐	☐
b)	Have you ever had, been told you have, or received treatment, medication, advice or counselling for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex, or had a positive test related to the HIV, HTLV virus or AIDS?	☐	☐
c)	At any time, in the last five (5) years, have you consulted a physician, or any Alternative Health Care Provider for any disease, ailment, injury or mental condition not already disclosed above? (Alternative Health Care Provider includes herbalist, acupuncturist, chiropractor, or practitioner of homeopathy, etc).	☐	☐
d)	Are you now under observation or taking treatment or medication from any physician or alternative health care provider for any disorder, ailment or condition?	☐	☐
e)	Do you have any condition for which hospitalization or surgery has been advised or is contemplated within the next 12 months?	☐	☐
f)	Have you used tobacco products within the last 12 months? (tobacco products include: cigarettes, cigarillos, cigars, mini-cigars, pipe smoking, chewing tobacco, nicotine gum or patch, marijuana or hashish)	☐	☐
g)	Have you ever been declined life or disability insurance or been offered insurance which has been modified or rated in any way? (If "Yes", please specify name of insurer, date and reason)	☐	☐

h) Your height ____________ (feet/inches) Your weight ____________ (lbs)

3. **If "Yes" to any of the preceding questions, please provide detailed information below:**

Question #	Details of Diagnosis, Duration, and Result	Date Treated	Name and Address of Physician/Hospital

RWAM Privacy Statement
RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.

Applicant Employee's Declaration and Authorization:

I hereby authorize any physician, hospital, clinic or any other medical or health care provider or facility, any insurance company, provincial health insurance plan, government department or agency, or any other person or organization having any medical or other relevant personal information or records regarding me to release to and exchange with RWAM Insurance Administrators Inc. ("RWAM") and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents, any and all information necessary for any or all of the following purposes: to underwrite my application for group insurance coverage, evaluate my eligibility for such coverage and adjudicate all insurance claims ("Purposes").

I authorize the release of information obtained during the underwriting process by RWAM and/or the relevant insurer(s) to my personal physician and to any reinsurers of my insurer(s), and when required to Public Health Authorities.

I further authorize RWAM and/or the relevant insurer(s), their respective authorized plan administrators, representatives and/or agents to request I undergo any such medical or paramedical examination(s) or evaluation(s) as may be required for the Purposes. I understand that my refusal or withdrawal of consent may result in the delay or denial of this application. I acknowledge that any information obtained from any paramedical or medical examination, any medical form(s), questionnaire(s) or any other written statements completed and furnished as evidence of insurability shall form part of this application and I declare that all such information and the information provided in this application to be true, complete and accurate. I acknowledge that any failure to disclose or any misrepresentation of any material fact may void my coverage. This authorization shall remain valid unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

____________________ *Date* ____________________ *Employee Signature*

This form must be received in our office within 60 days of the above date, otherwise a new form must be submitted.

APPLICATION FOR DIRECT DEPOSIT OF GROUP BENEFIT PAYMENTS

BENEFITS OF DIRECT DEPOSIT

Direct Deposit of Group Benefit Payments (otherwise known as Electronic Funds Transfer or 'EFT') allows RWAM to deposit your approved benefit payments directly into your personal/joint bank account.

A corresponding Explanation of Benefits ('**EOB**') statement will be sent to you, explaining the benefit payment.

Advantages of this convenient service include:

- Quick, safe and confidential
- Eliminates risk of lost or delayed benefit cheques
- Convenient, no extra trips to the bank
- Less paper, environmentally friendly

EMPLOYEE & BANKING INFORMATION

Employee Name ______________________ Group # __________ Certificate # __________

Attach Your Personal Account Cheque Marked "VOID"

Send my EOB to my personal e-mail address* at ______________________

Return this form and your VOID cheque by mail to: **RWAM Group Administration Department**
49 Industrial Drive
Elmira, ON N3B 3B1

If a void cheque is not included, complete the following:

Name(s) of Account Holder ______________________

Name & Address of Financial Institution ______________________

Bank # __________ Branch # __________ Account # __________

NOTES:

- You must be the sole or ***joint*** (generally jointly with your spouse) account holder & have signing authority.
- Applications for deposit to a third party's account will be rejected.

* **Disclaimer:** The transfer of any personal information by e-mail is not 100% secure. Your consent to transfer information by e-mail is given with this knowledge and understanding, and RWAM Insurance Administrators Inc. does not accept any responsibility for any interceptions of e-mails by unauthorized parties.

AUTHORIZATION

I hereby authorize RWAM Insurance Administrators Inc. to deposit Group Benefits (Extended Health, Dental and/or Disability) payments directly to my personal/joint bank account and to exchange my relevant financial information with my financial institution for such purposes. This authorization shall remain valid until revoked by me in writing. Any copy of this authorization shall be as valid as the original.

Employee Signature ***X*** ______________________ **Date** (yy/mm/dd) __________

RWAM Insurance Administrators Inc. is committed to protecting the privacy, confidentiality, accuracy and security of personal information it collects, uses, retains or exchanges in the necessary conduct of our business.