the benefits trust
Since 1994

For internal use only

Contract # _____

Reset Form

Auto Trim Benefits Plan Application

Applicant Information

Effective Date Requested

Legal Company Name: _____

(Month) _____ (Day) 01 (Year) _____

Operating as (if different): _____

Benefit Year _____
(if different from effective year)

Address: _____

City: _____ Province: _____ Postal Code: _____

Administrator Name: _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Executive Contact (if different): _____ Title: _____

Phone: _____ Fax: _____ Email: _____

Applicant's Declaration

The applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are full, complete and true as of the date hereof and expressly agrees and acknowledges that: (1) such statements and answers will form part of the group contract or policy issued by The Benefits Trust and/or its insurance partners; (2) the benefits coverage under the group contract or policy shall become effective in accordance with and subject to the terms of the group contract or policy issued to the applicant; (3) in no case shall coverage become effective until the later of the payment of the initial deposit and approval of this application by The Benefits Trust; and (4) The Benefits Trust will not be liable to the applicant or to any of the applicant's employees or any other persons proposed to be covered under this application until it has been approved. The attached Schedule of Benefits forms part of the application.

The initial deposit of $ _____ is included with this application. Negotiation of the deposit will not, of itself, constitute approval of the application. The deposit will be applied against the first month's contribution statement from The Benefits Trust.

Dated at _____ this _____ day of _____, _____

by _____ _____
(Applicant's signature) (Title)

_____ ☐ Take via Pre-Authorized Payment (PAP)
(Applicant's printed name) (Please complete the enclosed PAP form)

Business Information

Nature of Business: _____

Number of Years in Operation: _____ Ownership : ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

Name(s) of Owner(s) if Partnership or Sole Proprietorship: _____

Summary Employee Information

Number of Eligible Employees: _____ Regular Number of Hours Worked (for example 37.5 hrs or 40 hrs/week): _____

Contributions

The **Employer** will be paying the following percentage of contributions:

Notes:

☐ Please contact me regarding Healthcare Spending Accounts, Employee Assistance Plans, and/or TELUS Health Virtual Care

PAYOR'S AUTHORIZATION FOR PRE-AUTHORIZED DEBITS FOR BUSINESS PURPOSES

1. Payor's Name and Address – please print

   We warrant and represent that the following information is accurate.

Company Name		
Street		
Town	Postal Code	Telephone No.

Name of Payor's Financial Institution (the "Processing Institution")			
Street			Town
Postal Code	Bank No.	Transit No.	Account No.

   We have attached a specimen cheque marked "VOID" to this payor authorization (the "Authorization").

   We will inform the Payee, in writing, of any change in the information provided in this section of the Authorization prior to the next due date of the PAD.

2. Payee's Name and Address – please print

Name of Payee (the "Payee") The Benefits Trust		
Street: 3800 Steeles Avenue West, Suite #102W		
Town: Vaughan, Ontario	Postal Code: L4L 4G9	Tel: (905) 264-8990

3. We acknowledge that the Authorization is provided for the benefit of the Payee and the Processing Institution and is provided in consideration of the Processing Institution agreeing to process debits against our account, as listed above, (the "Account") in accordance with the Rules of the Canadian Payments Association.

4. We warrant and guarantee that all persons whose signatures are required to authorize withdrawals from the Account have signed the Authorization and that all persons signing this Authorization are our authorized signing officers and are empowered to enter into this agreement.

5. We hereby authorize the Payee to issue Pre-Authorized Debits (as defined in Rule H4 of the Rules of the Canadian Payments Association) (the "PAD") drawn on the Account, for the following purpose:
   - payment of group employee benefit plan.

6. We may cancel the Authorization at any time upon providing written notice to the Payee.

7. We acknowledge that provision and delivery of the Authorization to the Payee constitutes delivery by us to the Processing Institution. Any delivery of the Authorization to the Payee, regardless of the method of delivery, constitutes delivery by us.

8. Unless otherwise agreed to in writing, the Payee will provide to us, at the address provided in Section 1:

   a) with respect to fixed amount PADs, written notice of the amount to be debited (the "Payment Amount") and the date(s) on which the Payment Amount debited will be posted to our Account (the "Payment Date"), at least 10 calendar days before the Payment Date of the first PAD, and such notice shall be provided every time there is a change in the Payment Amount or the Payment Date(s);

   b) with respect to variable amount PADs, written notice of the Payment Amount and the Payment Date(s), at least 10 calendar days before the Payment Date of every PAD; and

   c) with respect to a PAD plan that provides for the issuance of a PAD in response to a direct action of ours (such as, but not limited to, a telephone instruction) requesting the Payee to issue a PAD in full or partial payment of a billing received by us for a payment obligation that meets the requirements of Section 2 or Rule H4, no notice is required.

9. The Payee may issue a PAD monthly including deposit (unless binder cheque is included) in a dollar amount as presented to the Payor and may vary with usage and taxes.

10. We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of the Authorization including, but not limited to, the amount, or that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued by the Payee on the Account.

11. Revocation of the Authorization does not terminate any contract for goods or services that exists between us and the Payee. The Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.

12. We may dispute a PAD only under the following conditions:
    (i) the PAD was not drawn in accordance with the Authorization;
    (ii) the Authorization was revoked; or
    (iii) pre-notification, as required under Section 8 was not received.

    We acknowledge that in order to be reimbursed a declaration to the effect that either (i), (ii) or (iii) took place, must be completed and presented to the branch of the Processing Institution holding the Account up to and including 10 business days after the date on which the PAD in dispute was posted to the Account.

    We acknowledge that when disputing any PAD beyond the time allowed in this section, it is a matter to be resolved solely between us and the Payee, outside the payment system.

13. We agree that the information contained in the Authorization may be disclosed to the Payee's Financial Institution as required to complete any PAD transaction.

14. We understand and accept the terms of participating in this PAD plan.

_____
(COMPANY NAME)

_____
(AUTHORIZED SIGNATURE)

_____
(AUTHORIZED SIGNATURE)