Rev 1013

BCMA Health Benefits Trust Fund
Employer Agreement with the Trustees

This is a legal agreement. Please read carefully before signing.

- Print clearly, in ink, and complete all pages of this form.
- Sign and date the form where indicated and forward the original form to the BCMA Health Benefits Trust Fund at the address below.
- Retain a photocopy for your files.

☐ New Application ☐ Change(s) to Existing Account

Agreement Between

The BCMA Health Benefits Trust Fund Trustees (the "Trustees") and:

Physician (or corporation name if applicable)

Address:

City | Province | Postal Code

Telephone Number: Area Code | Number

1. A reference in this agreement to:

   (a) "I" or to "me" or to "Employer" means the employer described above, whether an individual, corporation or partnership;

   (b) "BCMA" or the "Administrator" shall mean the British Columbia Medical Association as administrator of the BCMA Health Benefits Trust Fund;

   (c) The "HBTF Plan" means:

      (i) for a physician who is participating in the HBTF Plan, the extended health care and dental benefits provided by the Trustees, plus the optional Cost-Plus Portion of the Plan; and

      (ii) for Eligible Employees of the Employer (excluding however an employee who is a physician), the extended health care, dental, life, disability and accident benefits apply; and the Cost-Plus Portion of the Plan is optional, but if elected, must apply to all Eligible Employees;

   (d) "Cost-Plus Portion of the Plan" means, in reference to the HBTF Plan:

      (i) the maximum annual reimbursement which the Employer has set out in Schedule "A" (if no amount is specified, then the amount is $500 in a calendar year) for each physician who is participating in the HBTF Plan; and

      (ii) the maximum annual reimbursement which the Employer has set out in Schedule "A" (if no amount is specified, then the amount is $500 in a calendar year for each Eligible Employee of the Employer for which Cost-Plus Portion of the Plan has been added; and if Cost-Plus Portion of the Plan has not been added or if no employees of the Employer are listed in the list of Eligible Employees, then the amount is nil).

   (e) "Eligible Employees" shall have the meaning as set out in the HBTF Plan Booklet of the Trust Fund in effect from time to time.

2. I understand that this is a legal agreement between the Trustees and me. I apply to BCMA Health Benefits Trust Fund (the "Fund" or "Trust Fund") to participate in the HBTF Plan. This Employer Agreement sets out the

terms and conditions under which I, as an employer, may participate in the HBTF Plan provided by the Fund.

3. The participation of each Eligible Employee and the Employer in the benefit plans offered from time to time by the Fund is effective from the first day of the month immediately following receipt and acceptance of this Employer Agreement and all other required enrolment forms, or on such later date as is determined by the Trustees. I understand that there may be medical evidence requirements to obtain some of the benefits in the HBTF Plan, and satisfactory completion of those medical evidence requirements may be necessary for an Eligible Employee or physician to participate in those benefits.

4. I understand that:

   (a) the insurer may require that at least 75% of my Eligible Employees (or such other percentage as may be required by the insurer) who work 20 hours a week or more be enrolled in the HBTF Plan;

   (b) those of my Eligible Employees that I have agreed may participate in the HBTF Plan (if any) are listed in the "List of Eligible Employees" set out in Schedule "A" of this Employer Agreement; and

   (c) the Trust Fund may require in the future that a specified percentage of my Eligible Employees participate in the HBTF Plan or other benefit plan then offered by the Fund.

5. I understand that if I choose the HBTF Plan for myself as a participating physician, then I must choose to enroll my Eligible Employees or certain classifications of those Eligible Employees into the HBTF Plan.

6. I understand that if I choose the Cost-Plus Portion of the Plan benefit for any one or more Eligible Employees, I must choose Cost-Plus Portion of the Plan benefit for all of my Eligible Employees.

7. I understand that if I elect to participate in the Cost-Plus Portion of the Plan benefit for Eligible Employees (including any future Eligible Employees), then I agree with the Trustees and the Eligible Employees that I will reimburse and indemnify the Eligible Employees for the amount of any Cost-Plus benefits eligible for reimbursement (the “Eligible Benefit Claims”) in addition to paying an administrative fee to the Fund for processing such claims, for such length of time that the employment contract with the Eligible Employees are in good standing. I further agree that any liability that the Trust Fund may have to indemnify employees for Eligible Benefit Claims is limited only to what I have deposited with the Trust Fund to pay the Eligible Benefit Claims. I agree to indemnify the Trust Fund for any liability arising whatsoever with respect to the Eligible Benefit Claims.

8. I have completed Schedule “A” of this Employer Agreement listing the Eligible Employees (if any), the participating physician(s) and the other necessary information that the Fund needs.

9. I wish to participate in the HBTF Plan offered by the Trustees [**initial**]:

   (a) ☐ For each physician who is participating as set out in Schedule “A”.

   (b) ☐ For my Eligible Employees set out in Schedule “A”.

10. I understand that the Plan Summary/Details brochure of the Trust Fund and the HBTF Plan Booklet, which may be updated, revised, replaced or supplemented in the future by the Trustees, and the rest of this Employer Agreement sets out other terms and conditions of the agreement between the Trustees and me, as the employer. I will also consult with my tax or other professional advisor for other important information, details and restrictions which may apply to me, as employer.

GENERAL TERMS

By participating in the BCMA Health Benefits Trust Fund, I agree that:

1. I have received a copy of the Fund's Trust Agreement (or I have reviewed a copy on the BCMA website). I am familiar with the terms and conditions of the Fund's HBTF Plan and the Fund's Trust Agreement.

2. I will abide by all terms and provisions of the HBTF Plan, the Fund's Trust Agreement and the decisions of the Trustees.

3. I will pay the required Trust Fund benefit plan premiums on behalf of myself, my spouse, dependents and participating Eligible Employees.

4. I confirm that all of my Eligible Employees are listed on Schedule "A". By not listing employees on Schedule "A", I confirm that I do not have any Eligible Employees.

5. I will promptly notify the Fund in writing should the employment of any participating Eligible Employee terminate for any reason, or if I employ new Eligible Employees.

6. I am aware that upon approval by the Trustees, this Employer Agreement will come into effect on the date specified by the Fund through its Administrator, provided this Employer (participation) Agreement and the Plan application forms are complete. I also understand that to be eligible for some of the benefits, the insurer must also give its approval. I understand the Trustees may terminate this Employer Agreement by written notice to me. I agree to continue participation in the Fund and the HBTF Plan until such date that the Trustees process a written request of termination. I will send a request of termination by fax or mail to:

   Fax: (604) 638-2909

   Mail: **BCMA Health Benefits Trust Fund**
   c/o British Columbia Medical Association
   115 - 1665 West Broadway
   Vancouver, BC V6J 5A4

In any event that either party changes address, written notice shall be given to the other party.

Signature

I understand that upon acceptance of this agreement by the Trustees, it shall become a binding agreement between us in accordance with these terms and conditions, and binds me and my personal representatives, estate and successors.

This is a legal agreement. Please read carefully before signing.

Physician Signature *(if an individual)*	mm	dd	yyyy
Authorized Signature *(if a corporation)*	mm	dd	yyyy

For BCMA Health Benefits Trust Fund use only

Authorized Signatory for the Trust Fund	mm	dd	yyyy

BCMA HEALTH BENEFITS TRUST FUND

ELIGIBILITY DECLARATION

Please indicate which of the following applies to you (**check <u>all</u> that apply**):

☐ I am a new member of the BCMA and have joined for the first time within the last 90 days.

Date Joined
mm dd yyyy

☐ I have started a new practice or completed residency within the last 90 days and was not previously eligible for benefits through the Health Benefits Trust Fund.

Start date
mm dd yyyy

☐ I have lost benefits coverage under another group plan within the last 31 days, or will be terminating from that plan.

Date benefits are/will be terminated:
mm dd yyyy

Name of Insurer

Policy No.

☐ I do not qualify under any of the above conditions. I understand that evidence of insurability (proof of good health) for me and my employees (if any) will be required.

Signature

Physician Signature

mm dd yyyy

Physician Name (please print)

SCHEDULE A

LIST OF PARTICIPATING PHYSICIANS AND ELIGIBLE EMPLOYEES

Name of Participating Physician		Date of Birth	**Cost Plus Portion of the Plan** Tick box if you wish to add Cost Plus to your plan.	If you have chosen Cost-Plus Portion of the Plan, please set out the Maximum Cost-Plus Reimbursement for the Participating Physician in a Calendar Year. (See Note 2 below)
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$

Name of Eligible Office Staff Employee (working 20 hours per week or more) **DO NOT LIST DEPENDENT(S)**		Date of Birth	**Cost Plus** Tick box to add Cost Plus. If you add Cost Plus, you must add it for all Employees	If you have chosen Cost-Plus, please set out the Maximum Cost-Plus Reimbursement for the Eligible Employee in a Calendar Year. (See Note 2 below)
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$
First Name	Last Name	mm dd yyyy	☐ Cost-Plus	$

Note 1: A separate Enrolment Form from each Eligible Employee and Participating Physician, and other information, may be required by the Trust Fund or by the insurance company; and

Note 2: If Cost Plus Portion of the Plan is chosen, please specify either the amount of $500 for each Eligible Employee/Participating Physician (for a calendar year) or a higher amount if desired. If no amount is specified, then the amount is $500.

This personal information is being collected and used in order for the Eligible Employees and Participating Physicians to qualify for and receive benefits from the Fund.

BCMA HEALTH BENEFITS TRUST FUND

HBTF PLAN AND COST PLUS
DIRECT DEBIT AUTHORIZATION FORM

Personal Information

Name: _____
(please print)

Please indicate your E-mail address for payment confirmation purposes:

E-mail Address: _____

I (we) hereby authorize the BCMA as Administrator of the Trust Fund to withdraw my monthly Plan premium directly from my (our) bank account. I have attached a cheque unsigned and marked VOID for the account to be used for this purpose.

Bank Account Type:

☐ Personal
☐ Corporate (attach Certificate of Incorporation)

I/we will notify the British Columbia Medical Association (BCMA) in writing of any changes in the account information or termination of this authorization at least thirty (30) days prior to the next payment date. If I am not incorporated, I have designated the Personal Account I use for my business expenses.

I/we understand that termination of this authorization does not affect my/our obligation to pay for goods or services contracted for/with the BCMA.

My/our financial institution will treat each debit as if I/we had personally issued a written direction authorizing the BCMA to debit the amount(s) specified to my/our account and need not verify that payments are drawn in accordance with this authorization.

I/we understand that any debits charged to my/our account will be reimbursed if:

a) the debit was not drawn in accordance with this authorization;
b) this authorization has been terminated;
c) the debit was posted to the wrong account due to invalid/incorrect account information supplied by the BCMA

by giving notice in writing to my/our branch of account within ninety (90) days of the debit to my/our account.

I/we acknowledge that delivery of this authorization to the BCMA constitutes delivery to my financial institution.

Signature(s)

I/we warrant that all persons whose signatures are required to sign upon this account have signed this authorization.

* **For joint accounts, all depositors must sign if more than one signature is required on cheques issued against the account.**

_____ Signature mm dd yyyy

_____ Signature mm dd yyyy

To Be Completed By BCMA Health Benefits Trust Fund – DO NOT WRITE IN THIS AREA

Trust Fund Account Code: _____