

BCMA Health Benefits Trust Fund Member 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 it to the BCMA Health Benefits Trust Fund via email (insurance@doctorsofbc.ca), fax (604-638-2909) or mail.
- 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:

Name of Sponsoring Physician		BCMA ID #:	
Invoice to: Corporation/Business Name (if different from the Sponsoring Physician's Name)			
Address:			
City		Province	Postal Code
Telephone Number:	Area Code	Number	

- A reference in this agreement to:
 - "I" or to "me" or to "Member" or to "Employer" means the physician described above, whether an individual, corporation or partnership, and if I am not an employer then "I" or "me" refers to me as a physician who is participating in the HBTF Benefits plan;
 - The "Administrator" shall mean the British Columbia Medical Association (operating as Doctors of BC) as administrator of the BCMA Health Benefits Trust Fund;
 - The "HBTF Plan" means:
 - 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
 - for Eligible Employees of the Physician (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;
 - "Cost-Plus Portion of the Plan" means, in reference to the HBTF Plan:
 - the maximum annual reimbursement which the physician 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
 - the maximum annual reimbursement which the physician 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 physician 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 physician are listed in the list of Eligible Employees, then the amount is nil).
 - "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 Member Agreement sets out the terms and conditions under which I, as a physician, may participate in the HBTF Plan provided by the Fund.
3. The participation of each Eligible Employee and the physician 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 Member 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 Member 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 may choose to enroll my Eligible Employees or certain classifications of those Eligible Employees into the HBTF Plan. I must apply for the HBTF coverage in order to cover my Eligible Employees, however, may waive my participation in the plan if I have similar coverage elsewhere. If I currently do not employ any Eligible Employees, I am still eligible for participate.
6. I understand that if I choose the Optional Cost-Plus Plan for any one or more Eligible Employees, I must choose the Cost-Plus Plan benefit for all of my Eligible Employees.
7. I understand that if I elect to participate in the Optional Cost-Plus 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 allocated 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 Member 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 Member Agreement sets out other terms and conditions of the agreement between the Trustees and me, as the physician. I will also consult with my tax or other professional advisor for other important information, details and restrictions which may apply to me, as an 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 Doctors of BC 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 or have chosen not to enroll them under the plan.
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 Member Agreement will come into effect on the date specified by the Fund through its Administrator, provided this Member 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 Member Agreement by written notice to me. I agree to continue participation in the Fund and the HBTF Benefits Plan until such date that the Trustees process a written request of termination or the physician is no longer an active member of Doctors of BC. I will send a request of termination by fax, email or mail to:

Fax: (604) 638-2909
 Email: insurance@doctorsofbc.ca
 Mail: **BCMA Health Benefits Trust Fund**
 c/o Doctors of BC
 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.

A photocopy or electronic version of this agreement is as valid as the original.

Physician Signature <i>(if an individual)</i>	mm dd yyyy
Authorized Signature <i>(if a corporation)</i>	mm dd yyyy

FOR USE BY DOCTORS OF BC AS ADMINISTRATOR OF THE TRUST FUND – DO NOT WRITE IN THIS AREA

Authorized Signatory for the Trust Fund	mm dd yyyy

BCMA HEALTH BENEFITS TRUST FUND ELIGIBILITY DECLARATION



British Columbia Medical Association

Please indicate all which applies to you:

I am a new member of Doctors of BC and have joined for the first time:

Date First Joined

mm	dd	yyyy

I completed residency:

Date Completed

mm	dd	yyyy

I am currently enrolled in the Core Plus Plan, over age 55 and will be involuntarily losing coverage due to retirement or reduction of hours to less than 20 hours per week.

Retirement Date:

mm	dd	yyyy

I am losing my existing Extended Health and Dental coverage under another plan and would like to apply for coverage under the HBTF Benefits plan.

Name of my existing Extended Health and Dental Carrier

Policy No.

Date Previous Coverage Ended

mm	dd	yyyy

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

I confirm that all applicants (including dependents) are covered under a Provincial Health Care plan (ie BC MSP).

A photocopy or electronic version of this declaration is as valid as the original.

Signature

Physician Signature

mm	dd	yyyy

Physician Name (please print)

SCHEDULE A

LIST OF PARTICIPATING PHYSICIANS AND ELIGIBLE EMPLOYEES

**Name(s) of Participating Physicians
(Please do not list your dependents)**

**Optional
Cost Plus Plan**

Tick box if you wish to add Cost Plus to your plan.

If you have chosen to include the optional Cost-Plus Plan, please indicate the maximum reimbursement limit for the participating physician in a calendar year.
(See Note 2 below)

Name		Date of Birth			Optional Cost-Plus Plan	Reimbursement Limit
First Name	Last Name	mm	dd	yyyy	<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$

**Name(s) of Eligible Office Employees
(working 20 hours per week or more)**

**Optional
Cost Plus Plan**

Tick box if you wish to add Cost Plus to your Eligible Employees coverage.

If you have chosen to include the Optional Cost-Plus Plan for eligible employees, please indicate the maximum reimbursement limit for each employee in a calendar year.
Employees are required to provide a void Personal Cheque to participate.
(See Note 2 below)

Name		Date of Birth			Optional Cost-Plus Plan	Reimbursement Limit
First Name	Last Name	mm	dd	yyyy	<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$
					<input type="checkbox"/> Cost-Plus	\$

Note 1: A separate HBTF Enrollment Form from each eligible employee and participating physician is required. Additional information may be required by the HBTF Plan Administrator or by the insurance company during the application process; and

Note 2: If the Optional Cost-Plus 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 and the Cost Plus box is ticked, then a limit of \$500 will be assumed. This amount will include covered expenses for your eligible dependents as defined under the Income Tax Act. **Please ensure you discuss the Optional Cost-Plus Plan with your Accountant or Financial Advisor prior to selecting Cost Plus to ensure your eligibility and to discuss appropriate annual limits.**

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 OPTIONAL COST-PLUS PLAN 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 Doctors of BC 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 (attach void Personal cheque)
 Corporate (attach void Corporate cheque **AND** Certificate of Incorporation)
 Cost-Plus Plan* (attach both a Personal **AND** Corporate void cheque **AND** Certificate of Incorporation)
 *If you are enrolling employees in the Cost-Plus Plan, please also attach a void personal cheque from each employee

I/we will notify Doctors of BC 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, or if I do not have any business expenses, my Personal Account. I will also notify Doctors of BC in writing if I am no longer working as a physician or if my residence should no longer be in British Columbia.

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

My/our financial institution will treat each debit as if I/we had personally issued a written direction authorizing Doctors of BC 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:

- the debit was not drawn in accordance with this authorization;
- this authorization has been terminated;
- the debit was posted to the wrong account due to invalid/incorrect account information supplied by Doctors of BC;

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 Doctors of BC 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.**

A photocopy or electronic version of this authorization is as valid as the original.

Signature

_____|_____|_____
mm dd yyyy

Signature

_____|_____|_____
mm dd yyyy

TO BE COMPLETED BY DOCTORS OF BC ON BEHALF OF THE TRUST FUND – DO NOT WRITE IN THIS AREA

Doctors of BC Business ID: _____