Doctors of BC Health Benefits Trust Fund
Health & Dental Plan
Application Package – Sole Proprietor Physicians

Complete this package if:

- You are applying coverage for yourself (and your dependent family)
- You are a sole proprietor (not incorporated)

To apply for coverage, please submit <u>all</u> the following documents:

- ☐ **Completed and signed forms – Complete all yellow highlighted areas of the 8 page form below**
- ☐ **Void personal cheque**

You may submit the documents to insurance@doctorsofbc.ca or fax to 604-638-2909.

If you have any questions, please contact us at 1-800-665-2262 or insurance@doctorsofbc.ca. Thank you for choosing Doctors of BC for your insurance needs.

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.

[X] 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

1. A reference in this agreement to:

   (a) "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;

   (b) The "Administrator" shall mean the British Columbia Medical Association (operating as Doctors of BC) 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 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;

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

      (i) 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

      (ii) 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 physican 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).

   (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 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**]:

Initial here→

   (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.

X _____ _____
Physician Signature *(if an individual)* mm dd yyyy

X _____ _____
Authorized Signature *(if a corporation)* 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

doctors of bc
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

X

Physician Signature

mm dd yyyy

Physician Name (please print)

T 604 638 2908
F 604 638 2909
TF 1 800 665 2262

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

SCHEDULE A

LIST OF PARTICIPATING PHYSICIANS AND ELIGIBLE EMPLOYEES

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

First Name	Last Name	Date of Birth (mm dd yyyy)	**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)
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(s) of Eligible Office Employees
(working 20 hours per week or more)

First Name	Last Name	Date of Birth (mm dd yyyy)	**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)
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 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

doctors of bc
British Columbia Medical Association

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:

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 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.

X _____ _____
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: _____

T 604 638 2908
F 604 638 2909
TF 1 800 665 2262

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

0418

Health Benefits Trust Fund (HBTF) Plan

Enrollment Form

- Print clearly, in black or blue ink, and complete both pages of this form. **Incomplete forms will be returned.**
- Sign and date the form on the reverse and forward it to Doctors of BC at the address below.
- The applicant (and dependents) must be covered under a Provincial Health Care Plan (ie BC MSP) to be eligible to participate in this plan.
- Retain a photocopy for your files. **IMPORTANT**: The original Enrollment Form will be required in the event of a Life Insurance claim.

At Doctors of BC, we know that confidentiality of personal information is important. Go to https://www.doctorsofbc.ca/privacy-policy to view Doctors of BC's Privacy Policy. By participating in this Plan, you authorize Doctors of BC and its insurers to use the information collected on this form for benefits administration.

1. Personal Information

(Must be completed by ALL Applicants)

All applicants must be under age 65 at the time of application.

Plan details and changes will be sent to you via your provided Preferred Email Address.

Date of Employment and Earnings are not required for physicians applying for coverage.

Last Name | First Name | Middle Initial

Date of Birth (mm dd yyyy)

Date of Employment (or date working 20 hours per week) (mm dd yyyy)

Occupation

Gross Monthly Earnings (Office staff employees only): $

Preferred Email Address

Gender: ☐ Male ☐ Female

2. Group Life / AD & D

Must be completed by Medical office staff only.

Crossed off beneficiary designations must be initialed or request a Change of Beneficiary form from the HBTF Plan Administrator.

Physicians are NOT eligible for this benefit.

Select the Group Life/AD&D benefit you wish to apply for: ☐ $20,000 ☐ $50,000

Designated Beneficiary(ies) – In the event of my death, I name the person(s) below to receive the policy proceeds. To the extent permitted by Law, I reserve the right to change the beneficiary(ies) named below:

Last Name	First Name	Relationship to You	Percentage

If designating a beneficiary who is a minor or who lacks legal capacity please appoint a Trustee below. Before designating a Trustee, you should seek legal advice:

Full Name of Trustee	Relationship to You

3. Long Term Disability

Must be completed by Medical office staff only.

Physicians are NOT eligible for this benefit.

Select the monthly benefit amount you wish to apply for. *(**Please Note:** Coverage greater than $1,000 will require the employee to complete an Evidence of Insurability form and be approval by the carrier before coverage will be effective.)*

Taxable monthly benefit: (check one only)

☐ $ 1,000 ☐ $ 1,200 ☐ $ 1,500
☐ $ 2,000 ☐ $ 2,500

The amount selected should not exceed **85%** of gross monthly earnings.

4. Extended Health/ Dental Dependent Information

☐ Check if applying for single coverage only (no dependents).

If you wish to refuse this coverage, complete Section 5 on reverse.

An "eligible dependent" is defined as any person who is:

- Your legal spouse, or a person with whom you have lived for one year and have publicly represented as your spouse.
- Your unmarried dependent child(ren) under age 22, or under age 25 if a full-time student attending an educational institution recognized by the Canada Revenue Agency (CRA) and entirely dependent on you for financial support.

If applying for dependent coverage, complete the section below (attach a separate sheet if necessary). Dependent(s) not listed will be subject to proof of good health if application is made at a later date.

First Name	Initial	Last Name	Relationship (spouse/son/daughter)	Date of Birth mm dd yyyy
Spouse				
Child				
Child				
Child				

If any of the above dependent children are full-time students age 22 or over but under the age of 25, and entirely dependent on you for financial support; please indicate below the name of the student and the educational institution recognized by the CRA being attended in the spaces provided.

First Name	Name of educational institution recognized by the CRA

T 604 638 2908
F 604 638 2909
TF 1 800 665 2262

115—1665 West Broadway
Vancouver BC V6J 5A4

doctorsofbc.ca

5. Refusal of Benefits

Complete this section if you wish to refuse Extended Health Care and Dental Care for yourself and/or your dependent(s). **This will be allowed only if similar benefits are currently in force under your spouse's group policy.**

If you wish to add this coverage at a later date, satisfactory proof of good health for you and/or your dependent(s) may be required.

I refuse Extended Health and Dental coverage as I and/or my dependents are insured under my spouse's group policy.

For (check one only):

☐ Myself and my dependent(s) (if any)
☐ My dependent(s) ONLY

Current Insurer	Policy Number	Effective Date of Coverage mm dd yyyy

I understand that if my and/or my dependent(s)' coverage terminates under the policy indicated above, I can apply for coverage under this Plan within 31 days of loss of such coverage without proof of good health. If you do not make application within 31 days, you and/or your eligible dependents will be required to provide proof of insurability acceptable to carrier to be covered.

6. Applicant Signature

(Must be completed by ALL Applicants)

I am authorized to disclose information about my spouse and dependents in order to enroll them in the plan.

By enrolling in this Plan, I authorize the following:

Great-West Life Assurance Company ("Great-West Life"), its agents and service providers its reinsurers and their service providers to collect, use and disclose relevant information about me to underwrite, administer and adjudicate claims, my plan sponsor and its agents and Doctors of BC to use the information collected in this form for benefits administration and to make any necessary payroll deductions which may be required; Great-West Life, its agents and service providers and my plan sponsor and its agents to collect, use and disclose information about me, my spouse and dependents necessary for enrolment and purposes of continuing administration of the plan.

I declare that the information above is accurate and true.

X Applicant's Signature	mm dd yyyy

7. To be completed by Physician/Employer

(Must be completed by the sponsoring Member)

If you are a self-employed physician, you may name yourself or your Corporation as Employer)

Name of Physician or Employer (i.e. your corporation):	HBTF Business ID

Address:

City	Province	Postal Code

Telephone Number:	Area Code	Number	Fax Number:	Area Code	Number

I confirm that the Medical Office Staff Applicant is actively working in the office 20 hours or more per week.

I understand that if the Applicant is not actively working on the date coverage would normally become effective, it is my responsibility to notify the HBTF Plan Administrator as coverage will not become effective until the Applicant returns to active work.

Physician Member's Signature	mm dd yyyy

TO BE COMPLETED BY DOCTORS OF BC STAFF – DO NOT WRITE IN THIS AREA

Business ID: _____ **Member ID:** _____

Effective Date: _____ **Statement of Coverage:** _____

_____