

Group Health, Dental Plan & Critical Illness Plan

This benefit covers expenses over and above your Provincial Health Care Plans is for paid-up members and will be cancelled when membership is cancelled.

- 100% reimbursement for **prescription drugs** with a Pay Direct Drug Card and a deductible equal to the dispensing fee with a maximum of \$5000 per insured person per calendar year.
- 100% reimbursement for semi-private **hospital accommodation**
- 80% reimbursement (with no deductible) for: paramedical services to a maximum of \$500 per practitioner per insured person per calendar year including Chiropractor, Registered Massage Therapist, Naturopath, Psychologist, Osteopath, Speech Therapist, Podiatrist
- x-rays
- eye examination payable at \$35 every 24 consecutive months
- private-duty nursing
- ambulance services
- Hearing aids, Orthotics, etc.

Dental Care

80% reimbursement (with a \$25 single, \$50 couple/family deductible paid once per calendar year) on expenses for:

- diagnostics, scaling, cleaning, fluoride, extractions, fillings, x-rays
- oral examination recall every 6 months
- periodontic, endodontic, denture repair relining & rebasing and surgical services
- 50% reimbursement on expenses for bridgework, Caps, crowns and dentures.

To a maximum of \$1500 per insured person per calendar year for all Dental Services, expenses will be based on current Provincial Dental Fee Guides.

Critical Illness

One time payment of \$15,000, if diagnosed with any of the critical illness (such as cancer, Heart Attack, Stroke, Deafness, Multiple Sclerosis, Coma, Coronary Artery Bypass Surgery, etc.)

Premium (as of May 2009, revised annually)

Single coverage (if a member has not dependents) \$170.17 per month;

Couple (for member with one dependent) is \$344.42 per month;

Family (member, their spouse and any dependents under the age of 21) is \$381.46 per month.

For Ontario and Quebec residents, provincial sales tax applies. Canadian Residents only.

Notes

1. You must be a current paid-up member of SIP and resident of Canada to be eligible for benefits.
2. No medical evidence is required for eligible SIP members.
3. New members can apply for this plan within 31 days from the effective date of your SIP membership.

This plan is arranged by Smart Choice Benefits Inc and administered by Smart Choice Admin Inc.

Inquiries

For further information or enrolment forms, send an email to: rsvp@sipgroup.org or contact Max Haroon at 416-891-4937.

Society of Internet Professionals™ (SIP™)

Phone: (416) 891-4937 • www.sipgroup.org • email: info@sipgroup.org

09May01



Plan: SMARTCHOICE BENEFITS (Plan F)

Association Name: SOCIETY OF INTERNET PROFESSIONALS (SIP), Membership #

**This form is invalid without the current membership number.
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Membership Number _____

Membership Expiry Date : ____/____/____ Effective Date of Coverage
 /____/____ Month Day Year Month Day Year

Last Name: _____ Middle Initial: _____ First Name: _____

Current Occupation/Position: _____

____ Male ____ Female Email Address: _____ Date of Birth: _____
 ____/____/____ Month Day Year

Home Address: _____ Postal Code: _____

City: _____ Province: _____ Telephone () _____

Business Address: _____ Postal Code: _____

City: _____ Province: _____ Telephone () _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed ____ Separated

If Common Law, please provide the date the relationship began: _____

Type of Coverage Applying for:

- ____ SINGLE - For yourself only
- ____ COUPLE - For yourself, plus one dependent. (Complete dependent information.)
- ____ FAMILY - For yourself, spouse & children. (Complete dependent information.)

I hereby certify that the information given on this application form is correct and complete, and that it will be used for the application for the benefits which I am or will become eligible for under the group benefits plan.

x _____

x _____
 SIP Member's Signature

Date

Please send completed forms to:
 SMARTCHOICE

Tel (905) 660-0572 Fax (905) 660-4199

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DEPENDENT INFORMATION

Spouse

Last Name: _____ Middle Initial: _____ First Name: _____

Sex: _____ Male _____ Female

Date of Birth _____/_____/_____
Month Day Year

Children

1. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

2. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

3. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

4. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

5. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

6. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

7. Last Name: _____ First Name: _____ Date of Birth
_____/_____/_____

Month Day Year

Sex: _____ Male _____ Female

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CO-ORDINATION OF BENEFITS

** If you have alternate coverage through your spouse and would like to co-ordinate benefits, please fill in the following information and indicate which benefits you are co-ordinating.

Name of Spouse's Employer: _____ Name of Insurance Company _____

Health _____ Dental _____ Vision _____

Premium Authorization Agreement

To: SmartChoice Benefits Inc.
25 North Rivermede Road, Unit 19
Concord, Ontario
L4K 5V4

This letter will serve as an Agreement between _____ hereby called the "Payer" and SmartChoice Benefits hereby called the "Payee". The purpose of this agreement is to facilitate payment of the monthly premium for SmartChoice Benefits under the following terms and conditions.

This letter hereby authorizes its Bank,

Financial Institution: _____
Address: _____
Branch # _____ Transit # _____ Account # _____
To Pay \$ _____ as of the 1st of each month starting _____ / _____
month year

To Canadian Imperial Bank of Commerce (CIBC), being SmartChoice Benefits Inc.'s Bank, for credit to a SmartChoice Benefits designated account.

The Payer acknowledges that the monthly premiums may increase or decrease each year upon renewal. This Agreement hereby authorizes SmartChoice Benefits to increase/decrease the monthly premiums accordingly provided that SmartChoice Benefits notifies the Payer of any changes in monthly premiums at least (30) days prior to any rate changes becoming effective. The Payer hereby encloses a sample cheque marked "VOID" of the account to be debited.

The Payer hereby warrants that all persons whose signatures are required to sign this account have signed this Agreement below and that all persons executing this Agreement are duly authorized signing officers of the Payer and are empowered to enter into such an Agreement. It is fully understood and acknowledged that the authorization provided by this Agreement will remain in full force and effect until written notice of revocation is received by SmartChoice Benefits at least (30) days prior to the date of cancellation.

The Payer fully understands and acknowledges that Society of Internet Professional (SIP) is not a party to the Group Benefit Plan or this Agreement in any way whatsoever.

In the event that a payment is not honoured by the Payer's bank, then the Payer may restore the coverage by forwarding a certified cheque for the returned amount along with a reasonable service charge as set by SmartChoice Benefits Inc.

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Accepted by Payer:

Payee:

SMARTCHOICE BENEFITS INC.

Print Name

Signature

Date _____

Date _____