enVia
Benefits by Choice

Health Spending Account + RRSP Option

A better choice for both employer & employee

The **enVia Benefits by Choice Program** is a unique combination of a **Health Spending Account (HSA)** and a **Registered Retirement Savings Program (RRSP)** designed to provide employers with cost-controlled health, dental & other benefits, and employees with much greater flexibility in terms of what the funds can be spent on!

Works like
a Health & Dental
Bank Account

- ✓ **No annual inflationary increases** - employer defines annual cost
- ✓ **No wasted premiums** - unspent HSA amounts carry forward to 2nd year
- ✓ **Employee choice** - direct contributions to Healthcare, RRSP or both - great for people who already have spousal coverage!
- ✓ Operates like a **Health & Dental Bank Account with 24/7 online access**
- ✓ **Employees can now claim expenses not normally covered!**
- ✓ **Includes MDM Pay-Direct Health Benefits Card**
- ✓ **HSA includes Excess Medical Insurance** to provide additional umbrella of critical illness protection (underwritten by Western Life Assurance Company)
- ✓ **Includes AIG Special Risk AD&D, Travel Attachè Services** & **Employee & Family Assistance Program**
- ✓ **Everyone qualifies** - no health evidence required for HSA (employees must work at least 20 hours per week)


MDM
GUARD CARD
(800) 838-1531

Employee: JOHN SMITH
Subscriber/Client ID #: 01234567890
Group Policy #: 9999-999A
Coverages: Extended Health Care, Dental

enVia
BENEFITS PROGRAM

For coverage details, please refer to your Employee Benefit Booklet or visit www.mdm-insurance.com

Use of this card authorizes the following to exchange information concerning underwriting, administration, paying claims and patient safety: MDM Insurance Services Inc.; any person or organization who has relevant personal information about me or my spouse or dependents including health care practitioners; institutions and insurers; and any person performing services for MDM Insurance Services Inc.

Includes MDM
Pay-Direct Health Benefits Card

RRSP option provides greater flexibility:

Employees who have adequate health and dental coverage through a spousal plan, or who enjoy good health and have few medical claims each year may choose to direct some or all of the employer contribution to an RRSP. A variety of investment options are available to the employee, and the amounts allocated to the RRSP vest immediately.

enVia Benefits By Choice Program
19 Peony Street, Markham, ON L6B 1K9
416-453-9430 phone | 1-877-755-9670 toll-free | 416-446-7371 fax | info@envia.ca

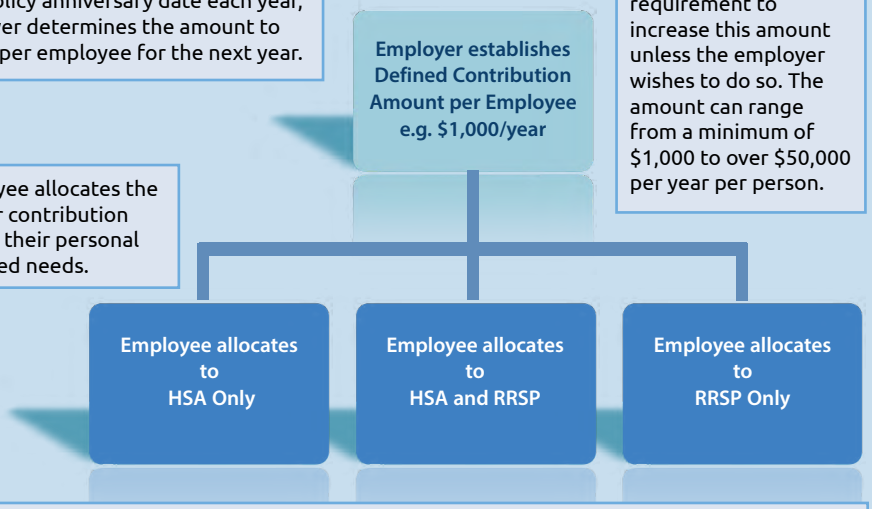
enVia
Benefits by Choice

The **enVia HSA** functions as a health & dental "bank account" to which the employer makes a pre-defined annual or monthly contribution. This amount remains fixed for as long as the employer wishes - and is **not subject to the annual inflationary cost increases** imposed by insurers under a typical group benefits plan. This budget-friendly "defined contribution" approach lets the employer enjoy **fixed & predictable cost control.**

How it works:
1. At the policy anniversary date each year, the employer determines the amount to contribute per employee for the next year.

2. There is no requirement to increase this amount unless the employer wishes to do so. The amount can range from a minimum of $1,000 to over $50,000 per year per person.

3. Employee allocates the employer contribution based on their personal anticipated needs.



4. "Inflationary and trend" factors imposed by insurers under traditional health and dental programs disappear! Employer gets fixed, determinable costs while employee enjoys better, more flexible coverage.

Meanwhile, the **employee decides how the available funds will be spent** to meet his/her personal protection needs. This can mean directing all of the funds to a Health Spending Account or to an RRSP, or to a combination of both! Most importantly, **employees can now claim expenses not normally covered** by a traditional health & dental plan - things like Laser Eye Surgery, Orthodontia, Dental Implants and even the therapy costs for Autistic children, for example.

Sample claimable expenses:

Acupuncture (BC only)*	Occupational Therapist
Artificial Limbs	Optician
Athletic Therapy*	Optometrist
Attendant Care	Orthodontics / Dental Braces
Birth Control Pills**	Orthopedic Shoes
Breast Reduction Surgery	Oxygen & Equipment
Chinese Medicine*	Physiotherapist
Chiropodist	Podiatrist
Chiropractor	Prescription Drugs
Contact Lenses**	Psychologist
Contraceptive Devices**	Psychotherapy*
Crowns & Bridgework	Psychiatrist
Dental Implants & Veneers	Registered Masseur
Dental Treatment	Skin Care (Non-Cosmetic)***
Dentures	Therapy Equipment
Dermatologist Fees***	Van/Vehicle Conversions****
Fertility Treatments	Vein Removal
Gastric Bypass / Stapling	Viagra®, Cialis®, Levitra®
Hydrotherapy**	Vitamins**
Insulin & Diabetic Supplies	Wheelchairs
Laser Eye Surgery	X-rays
& more****	

* Must be performed by a licensed medical practitioner;
** Must be prescribed by a licensed medical practitioner and dispensed by a licensed pharmacist / medical practitioner as part of their medical services;
*** Must be medically necessary;
**** As per Section 118.2 (2) of the Federal Income Tax Act and Income Tax Folio S1-F1-C1 Medical Expense Tax Credit.

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info@envia.ca

enVia Benefits by Choice Program Application Form

For more information or assistance in completing this application, or to request additional applications & health statements, please contact us.

1 General Information

Effective Date of Coverage Requested: _____

YOUR NAME (LAST NAME / FIRST NAME / INITIAL)			MARITAL STATUS ◯ MARRIED ◯ SINGLE ◯ COMMON-LAW ◯ OTHER _____	
DATE OF BIRTH (DD/MM/YYYY)	SEX ◯ MALE ◯ FEMALE	LANGUAGE ◯ ENGLISH ◯ FRENCH	PRIMARY OCCUPATION	ANNUAL EARNINGS
HOME ADDRESS	CITY	PROVINCE	POSTAL CODE	
HOME TELEPHONE	WORKPLACE TELEPHONE	FAX		
EMAIL ADDRESS	DATE OF HIRE (DD/MM/YYYY)	YOUR EMPLOYMENT STATUS ◯ FULL-TIME EMPLOYEE ◯ HOURLY		
MEMBER FIRM	BUSINESS ADDRESS	CITY	PROVINCE	POSTAL CODE

2 Dependent Information

Last Name	First Name & Initial	Sex (M/F)	Birthdate (DD/MM/YYYY)	Child Aged 21-25 (or 25+ if Disabled)
Spouse:				
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED
Child:				◯ STUDENT ◯ DISABLED

If a Child is over age 21, state if a Student or Disabled. Students only covered up to age 25 and must provide proof of attendance at school (ie. a copy of their student card).

3 Benefit Coverage

☑ **"Benefits by Choice" Program**

Employer contributes "defined amount" of $ _____ per month to Program.

Employee allocates funds to: (please indicate how much of the monthly contribution to allocate to the HSA, the RRSP or a portion to each)

$ _____ / month to HSA

(BHH Health Spending Account - includes $1M Excess Medical Insurance with Deductible of $2,500)

$ _____ / month to RRSP

(Please note a separate application is required for the RRSP and contributions are considered taxable income; you will, however, be issued an official tax receipt to claim on your personal Income Tax Return)

◯ **Single Plan** ◯ **Couple Plan** ◯ **Family Plan** (If you have allocated any funds to the HSA above, please indicate your coverage level here)

OPTIONAL:

☐ I wish to make additional voluntary contributions to the Group RRSP in the amount of $ _____ per month.

☐ I have entered into a "Compensation Adjustment" with my employer in order that additional contributions of $ _____ per month will be made by my employer to my HSA. (Separate written agreement with employer required)

4 ☑ AIG Special Risk Insurance Program (mandatory, automatically included):

Provides $20,000 of Accidental Death & Dismemberment Insurance in Canada on a 24/7/365 basis, plus Attaché Services including Identity Theft Recovery Assistance.

Beneficiary Designation: (applies to AIG Special Risk Insurance)

◯ REVOCABLE ◯ IRREVOCABLE

BENEFICIARY(IES) SURNAME(S), GIVEN NAME(S) & INITIAL(S)_____

RELATIONSHIP OF BENEFICIARY TO INSURED_____ **If beneficiary is under age of majority, please complete TRUSTEE section**

I, the undersigned applicant, hereby appoint the person(s) stated as my beneficiary(ies) on my current and future insurance benefits and understand that I may, without restriction, change my beneficiary at any time in the future.

Applicant's Signature X_____**Date**_____

DECLARATION APPOINTING TRUSTEE (complete if beneficiary is under age of majority)

I do hereby appoint_____as Trustee to receive any amount due to any beneficiary under the age of majority and declare receipt of such Trustee shall be in good discharge to the insurer for the amount so paid. And I hereby authorize such Trustee, within his/her discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at_____**this**_____**day of**_____**20**_____

Applicant Signature_____

5 ☑ Workplace Options Employee & Family Assistance Program (mandatory, automatically included):

Provides up to 3 hrs/family member of confidential telephonic counselling by professionals for life/work issues & referral for ongoing requirements anywhere in the world.

6 Declaration & Authorization

I acknowledge that Personal Information collected with this Application for a Health Spending Account (including Excess Medical Insurance and Accidental Death & Dismemberment Insurance) is confidential and will not be used for any purpose other than in conjunction with this request for, and subsequent administration of, the health insurance protection that is afforded to Applicants, Spouses, and Dependent Children under this plan.

I understand that this application is for a Health Spending Account established in accordance with the Income Tax Act Interpretation Bulletins IT-339R2 & Income Tax Folio S1-F1-C1 Medical Expense Tax Credit, and includes coverage for Excess Medical Insurance and Accidental Death & Dismemberment Insurance. It is administered by MDM Insurance Services Inc. (MDM), a Pharmacy Benefits Manager and Third Party Administrator. MDM will not be liable for any claims where the participant failed to provide complete and accurate information. I understand that claims must be submitted within 30 days of the end of a calendar year for the claims incurred in the prior year, and that unused funds carry forward for one year only and if not used then are forfeited to the contributing employer. The funds are held in a Trust Account by MDM and no interest is credited. Unused funds cannot be returned to individual participants.

The Excess Medical Insurance is underwritten by the Western Life Assurance Company.

The Optional Travel Insurance is underwritten by Berkley Canada (a W. R. Berkley Company) and administered by WTP Assist.

The AIG Special Risk AD&D Insurance is underwritten by AIG Insurance Company of Canada.

This program may be terminated at anytime by either party on 30 days written notice. This Application/Enrolment form together with the participant booklet constitutes the entire Agreement. No Agent, Broker or other person has authority to waived any condition of this Agreement. Participants will be able claim up to the balance in their account at anytime and may access their account status online 24/7.

Signed at: _____, _____ this _____ day of _____, _____ Applicant's Signature **X**_____

CITY / TOWN PROVINCE DATE MONTH YEAR

Privacy & Confidentiality We protect our customers' confidential information. A combination of industry, legislated and our own corporate privacy and confidentiality requirements govern the level of detail shared about any plan member and his or her dependents' benefits. In terms of telephone inquiries to the Insurer's or the Plan Administrator's Customer Service Dept., the information provided varies based on the relationship of the person making the inquiry to the insured (e. g. plan administrator, plan member or dependent). After the caller has been screened for appropriate identification, only information pertaining to the specific claim or treatment in question is shared.

Please mail, fax or scan & email this application to the appropriate address below.

enVia Benefits By Choice Program
MDM Insurance Services Inc.
834 Gordon Street
Guelph, ON N1G 1Y7

Phone: (519) 837-1531
Toll-free: 1-800-838-1531
Fax: (519) 836-4909
E-mail: info@envia.ca

enVia
HEALTH SPENDING ACCOUNT

Health Spending Account Cost Summary – July 1, 2015
ON & MB ONLY

Net Annual Amount Contributed to Employee's HSA	Administration Fee	EXCESS Medical Insurance Premium/Month + EAP & AD&D (Incl.Taxes)(Mandatory)	Total Monthly Cost Per Person
$1,000 ($83.33/mo.)	$10.00/mo.	Single $17.38 Couple $32.42 Family $39.26	Single: $110.71 Couple: $125.75 Family: $132.59
$1,200 ($100.00/mo.)	$12.00/mo.	As above	Single: $129.38 Couple: $144.42 Family: $151.26
$1,500 ($125.00/mo.)	$15.00/mo.	As above	Single: $157.38 Couple: $172.42 Family: $179.26
$1,800 ($150.00/mo.)	$18.00/mo.	As above	Single: $185.38 Couple: $200.42 Family: $207.26
$2,000 ($166.67/mo.)	$20.00/mo.	As above	Single: $204.05 Couple: $219.09 Family: $225.93
$2,500 ($208.33/mo.)	$25.00/mo.	As above	Single: $250.71 Couple: $265.75 Family: $272.59
$3,000 ($250.00/mo.)	$30.00/mo.	As above	Single: $297.38 Couple: $312.42 Family: $319.26
$3,600 ($300.00/mo.)	$36.00/mo.	As above	Single: $353.38 Couple: $368.42 Family: $375.26
$4,000 ($333.33/mo.)	$40.00/mo.	As above	Single: $390.71 Couple: $405.75 Family: $412.59
$5,000 ($416.67/mo.)	$50.00/mo.	As above	Single: $484.05 Couple: $499.09 Family: $505.93
$6,000 ($500.00/month)	$60.00/mo.	As above	Single: $577.38 Couple: $592.42 Family: $599.26
$7,500 ($625.00/month)	$72.00/mo.	As above	Single: $717.38 Couple: $732.42 Family: $739.26
$10,000 ($833.33/month)	$100.00/mo.	As above	Single: $950.71 Couple: $965.75 Family: $972.59

E & O Excepted Maclagan Inc.

PRIVATE & CONFIDENTIAL
Pre-Existing / Chronic Condition Reporting Form for Excess Medical Insurance

Purpose: To report confidentially any chronic or pre-exisiting conditions, treatments or medications.

Why: While participants are immediately covered for any eligible newly diagnosed conditions, treatments or medications, there is a 24 month waiting period from your effective date of coverage for any pre-existing or chronic conditions before those expenses will be covered / reimbursed under the Excess Medical Insurance Policy. **THIS ONLY APPLIES TO THE EXCESS MEDICAL INSURANCE - YOUR HEALTH SPENDING ACCOUNT STILL ALLOWS YOU TO CLAIM ANY ELIGIBLE EXPENSE FROM DAY ONE.**

Scope: This form should be completed both for the applicant and any eligible dependents.

Will reporting a condition have any impact whether or not I get approved? No, the plan is offered on a guaranteed issue basis. Reporting a pre-existing or chronic condition here only allows the administrator to determine the date after which your current medications / treatments will be covered / reimbursed under the Excess Medical Insurance Policy.

What will happen if I fail to report a pre-existing or chronic condition? Failure to disclose pre-existing or chronic conditions may result in the rejection of certain drug / treatment claims and / or termination of all coverage.

Will my employer be made aware of any information on this form? No, this form is strictly confidential. The information provided will be kept confidential and will not be shared with your employer or any party other than the Insurer and the Administrator, MDM Insurance Services Inc., the provider of the Pay-Direct Card.

Name: _____ Employer: _____

Email: _____ Home Tel: _____ Work or Mobile Tel: _____

List Pre-Existing / Chronic Conditions	Medications being taken	Applies to (Self or Dependent's name)	Prescribing Physician's Name & Telephone Number

I certify the above information to be a full and complete disclosure of any and all of my or my dependent's pre-existing or chronic conditions of which I am currently aware and treatment has been received or counselled and/or for which medication or treatment has been prescribed or recommended. I agree that the Insurer or its Service Providers may, if necessary, contact my or my dependent's personal physician to determine the nature of a condition for which medication has been prescribed.

_____ _____

(Signed) (Date)

Please retain a copy for your records and mail the completed form directly to:

PRIVATE & CONFIDENTIAL
enVia Benefits Program
MDM Insurance Services Inc.
P.O. Box 970
Guelph, ON N1H 6N1

Or FAX this form to: (519) 836-4909

MDM Insurance Services Inc.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

enVia Benefits Program Invoice Payment

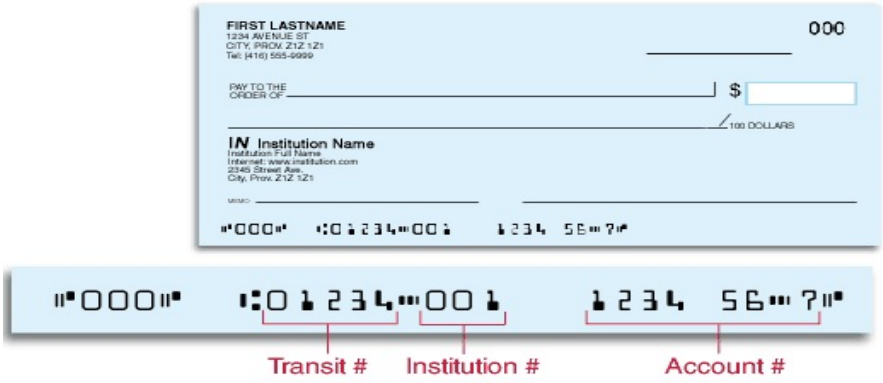
Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Complete (or attach a blank cheque marked "VOID") and return this form to authorize Electronic Funds Transfer (EFT) payment and/or e-mail notification of your invoices.

Name: _____ Policy Number: _____

Name of Financial Institution: _____

Transit #: | | | | | | Institution #: | | | | Account #: | | | | | | | | | | | | |



Payment Method and Notification Options

☑ Monthly Invoicing with EFT withdrawal

☐ Receive an e-mail with your invoice included as a password-protected file attachment.

E-mail Address (please print clearly): _____

Password (must be at least 6 characters): _____

Please return this form to: MDM Insurance Services Inc., P.O. Box 970, Guelph, ON, N1H 6N1 or fax it to: 519-836-4909

I/We hereby authorize MDM Insurance Services Inc. (MDM) through The Bank of Nova Scotia to collect payment of monthly or other periodic billings for services supplied by MDM, by means of Electronic Funds Transfer (EFTs) drawn against my/our account at the financial institution shown on the Authorization form. I/We hereby waive any requirement for pre-notification of changes in the amounts and/or payment dates of EFTs drawn against my/our account at my/our Financial Institution. I/We will notify MDM Insurance Services Inc. 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. I/We understand that termination of this authorization does not affect my/our obligation to pay funds owing for claim payments, administrative expenses, and applicable taxes.

_____ _____

Authorized Signature Date

_____

(additional signatures if more than one signature is required on cheques issued against the account)

Rev. 2015/05/29

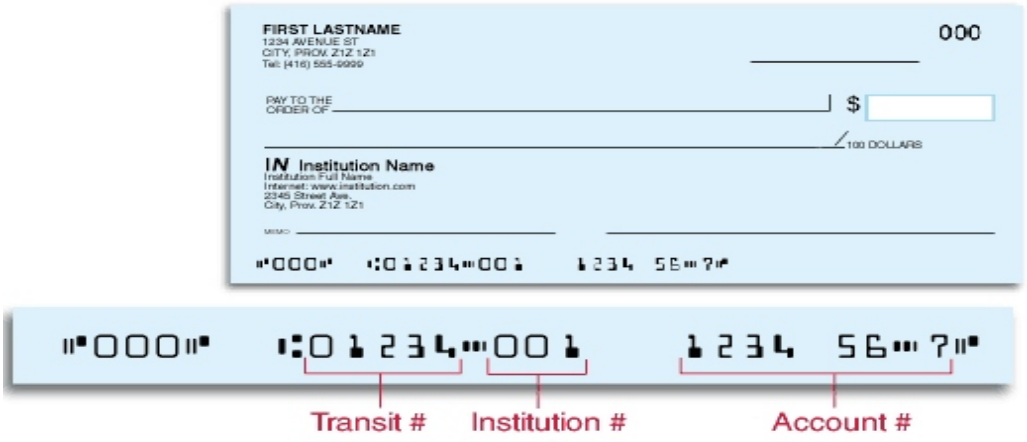
MDM Insurance Services Inc.

DIRECT DEPOSIT APPLICATION

Complete and return this form for direct deposit of claims payment and electronic delivery of your Explanation of Benefits. Please return this form to: MDM Insurance Services Inc., P.O. Box 970, Guelph, ON, N1H 6N1.

Privacy Statement
MDM Insurance Services Inc. ("MDM") is committed to protecting the privacy, confidentiality, accuracy and security of the personal information that it collects, uses, retains and discloses in the course of conducting business.

Employee/Member's Name:	
Group Policy Number:	
Name of Employer:	
Name of Financial Institution:	
Institution Number (3 digits):	
Transit (Branch) Number (5 digits):	
Account Number:	
E-mail Address:	
Employee/Member's Signature:	**Date**:



Providing our office with the above information, you as the account holder, are authorizing MDM Insurances Services Inc. and your financial institution to credit directly to your account your and your eligible dependents (if applicable) Extended Health Care, Dental, Health Spending Account and/or Weekly Indemnity claim payments; issue corresponding Explanation of Benefits (EOB) via e-mail to an address provided by yourself (if applicable); and assign a Personal Identification Number allowing exclusive access to your EOB messages on-line through the World Wide Web.

2004/9/13