Please mail original, completed form to:

bClear benefits
Suite 120 – 4401 Still Creek Drive
Burnaby, BC V5C 6G9

Application for Atrium

Company Name: _____
Name of Employer (print full legal name as it should appear in the policy)

Mailing Address: _____
Street Number

_____
City Province Postal Code

Contact Information: _____
Telephone Fax

Contact Person: _____
Full Name Title E-mail

Billing Contact:
(If different from above) _____
Full Name Title E-mail

Member of Professional Association: ☐ Yes ☐ No **Number of years in business:** _____

Name of Association(s): _____

Effective Date Requested: 1st day of _____ , 20 _____

Number of Eligible Employees Covered Under the Plan: ☐ 1 ☐ 2

NOTE: To avoid a period without coverage, do not terminate existing coverage until the effective date of coverage is formalized.

APPLICANT INFORMATION

	YES	NO
1. Are there any plan members currently receiving disability benefits under a group plan, WCB or any other source?	☐	☐
2. Has the current insurer waived the life insurance premium for any applying plan members?	☐	☐
3. Is anyone currently absent from work due to sickness or injury?	☐	☐
4. Is anyone NOT covered by Workers' Compensation?	☐	☐
5. Is anyone NOT covered by Employment Insurance?	☐	☐

Question #_____ Full Name: _____

Question #_____ Full Name: _____

APPLICANT ELIGIBILITY

Eligibility: **Member in good standing in their Professional Association**

Minimum Hours Worked Per Week: **30 hours**

Province of Residence: **British Columbia**

APPLICANT'S COMMITMENT

1. The Atrium plan is available for a maximum of two insured individuals with the same company.
2. Applicants must be actively at work for insurance to take effect.
3. Submit all outstanding claims, including those for waiver of premium benefits, to the prior carrier within 30 days of cancellation of coverage.
4. Premiums are due on the first day of each billed month and should be paid to **BCCA Employee Benefit Trust**.
5. Rates are subject to change at each renewal.
6. We require 31 days written notice of plan terminations.

In connection with this application to the insurance carrier(s), the Applicant:

A) Declares that to the best of the Applicant's knowledge, the statements and answers contained herein are full, complete and true;

B) Agrees that the insurance shall become effective in accordance with the policy but in no event will it become effective until the first monthly premium has been paid; and

C) That by accepting coverage under the policy, the Applicant acknowledges and confirms the provisions and conditions contained in it, including additions or amendments. BCCA Employee Benefit Trust may agree with the insurers to make amendments without consulting the Applicant.

☐ I would like to receive information, newsletters, and other communication from **bClear benefits** and other organizations associated with **bClear benefits**.

SIGNED AT _____ THIS _____ DAY OF _____, 20_____

BY _____

(signature and title of authorized official)