Exceptional Expense Insurance Application Form
New Small Group (1-5)

Agent Name: ________________

CLIENT ACCOUNT INFORMATION

Legal Company Name

Premium Payment Frequency, **Annually**

Annual Payments will be processed on the plan effective date, and on each renewal date. Changes to the number of plan members will be billed or credited accordingly.

EXCEPTIONAL EXPENSE INSURANCE

Exceptional Expense Insurance Effective Date: _____ (mm) 01 (dd) _____ (yyyy)		Exceptional Expense Insurance Renewal Date: 01 (mm) 01 (dd) _____ (yyyy)	
First Year Premium & Management Cost Calculation		**Second & Subsequent Year Cost Calculation**	
Monthly fee per employee	**$6.00**	Monthly fee per employee	**$6.00**
Number of employees	x	Number of employees	x
Number of months to year-end (12/31)	x	Number of months to year-end (12/31)	x **12**
1st year premium	**$**	**Annual premium**	**$**

NOTE: Where spouses are listed as separate participants in the PHSP, only one should be enrolled to this insurance plan and the other will be covered as a dependant. Employer will be billed an Administration fee, as determined by the Group Contract, on all claims processed under the Exceptional Expense Insurance plan. First year benefits will be prorated from the effective date to the end of the calendar year.

Exceptional Expense	Eligible Benefit Amount	Benefit Term
Accidental Dental	$ 5,000	Calendar Year
Ambulance	$ 5,000	Calendar Year
Convalescent Care	$10,000	Calendar Year
Private Duty Nursing	$10,000	Calendar Year
Semi-Private Hospital	$ 5,000	Calendar Year
Wheelchairs, etc.	$ 5,000	2 Calendar Years

Insurance Terms

The applicant hereby requests that Echelon General Insurance Company issue an Insurance policy based on the statements and representations stated herein. Furthermore, the applicant hereby declares that, to the best of the applicant's knowledge, the statements and answers contained herein are complete and true as of the date hereof and agrees that such statements and answers shall constitute the application for and form part of the contract and that the insurance shall become effective in accordance with and subject to the terms and conditions of the policy to be issued to the applicant but in no case shall it become effective until the application has been approved by the Insurer. In case of errors or omissions discovered by the Insurer in this application, the Insurer is hereby authorized to amend this application by noting the changes. Acceptance by the applicant of the policy accompanied by a copy of the amendments shall constitute a ratification of such corrections and modifications. It is the responsibility of the applicant to notify the group members of the termination of coverage in the event that the Insurance is cancelled at any time by the applicant, Olympia Trust, or the Insurer. Coverage will be considered a 'standing-order', if cancellation is desired the applicant **must** inform Olympia Trust.

Addition to Employer Administrative Services Agreement with Olympia Trust Company

☐ By initialing below, I acknowledge that I am authorized to bind the company named above and I agree that this Exceptional Expense Insurance Application form and the fees outlined herein will become part of the Group Application form and the Administrative Services Agreement therein as fully as if it were stated at length over my signature on said Application and Administrative Services Agreement.

Employer Initials: ________________________________

Acknowledgement and Acceptance for **Olympia Trust Company** by: ________________________________

ECHELON GENERAL INSURANCE COMPANY

Exceptional Expense Insurance Plan

OLYMPIA Trust Company

BENEFIT SUMMARY

COVERED EXPENSE	MAXIMUM BENEFIT LIMIT PER PERSON	BENEFIT TERM
Ambulance ($1,500 per-trip maximum)	$5,000	Calendar Year
Accidental Dental*	$5,000	Calendar Year
Convalescence Home Care*	$10,000	Calendar Year
Semi-Private Hospital*	$5,000	Calendar Year
Private Duty Nursing*	$10,000	Calendar Year
Ambulatory Assistive Devices*	$5,000	2 Calendar Years

* These benefits are subject to a six (6) month wait-period upon initial enrolment for pre-existing conditions.
Note: First year benefits are prorated from the effective date to the end of the calendar year.

BENEFIT DETAILS

This Policy will reimburse you for charges incurred by you or your Dependents for any of the following Eligible Expenses, to the extent that they are reasonable and customary, and provided they are Medically Necessary for the treatment of sickness or injury and recommended by a Physician, and the expenses are incurred for the care of a person insured under this Policy.

1. **Ambulance** expenses incurred for service to and from the nearest hospital where adequate treatment is available to a maximum of $5,000 per person per calendar year and $1,500 for any one trip.
2. **Accidental Dental** expenses incurred for the repair or replacement of sound natural teeth, when the injury is caused by an external accidental blow to the head or mouth, excluding injuries caused from objects placed in the mouth to a maximum of $5,000 per person per calendar year.

   The injury must have occurred after the effective date of this Policy, in order for the expenses to be considered eligible for reimbursement.

   We must be notified within sixty (60) days following the date of the accident and treatment must be completed within twelve (12) months following the date of the injury.

   Payment for such services will be based on the Dental Association Fee Schedule for general practitioners in the province or territory in which the services are rendered in effect on the date treatment commences.
3. **Convalescence Home Care** expenses incurred after hospitalization for service provided in your home primarily for custodial care, homemaking duties, or supervision to a maximum of $10,000 per person per calendar year.
4. **Hospital Care** expenses incurred in excess of the hospital's public ward charge, for semi-private accommodation to a maximum of $5,000 per person per calendar year.
5. **Private Duty Nursing** expenses incurred for services provided in your home (other than custodial care, homemaking services and supervision) by a Registered Nurse, a Registered Nursing Assistant, a Certified Nursing Assistant, or a Licensed Practical Nurse, to a maximum of $10,000 per person per calendar year. The services provided must be services which are deemed to be within the practice of nursing.

   Charges for the following services are not covered:
   a) services performed by a nursing practitioner who is an Immediate Family Member or who lives with the patient;
   b) services performed while the patient is confined in a hospital, nursing home or similar institution;
   c) services which can be performed by a person of lesser qualification, a relative, friend, or member of the patient's household.
6. **Wheelchairs and Related Ambulatory Assistive Device** expenses incurred for the rental of a wheelchair, walker or crutches, or the purchase of a splint or brace, to a maximum of $5,000 per person over any two calendar year period. In order to be eligible the equipment or supplies must be rented or purchased for post care following a treatment that is emergency-related and supported by a written order from the attending Physician.

COST SUMMARY

Premiums are $6.00 per month per member. Administration fee on claims processed under the Exceptional Expense Insurance plan is as-specified in the Group Contract.