coreHEALTH+™

A core benefit program you can build on

Incorporated Companies and Sole Proprietors

“Simply Brilliant!”

Spend **Less** with **More** choices!

Finally... a Health Care Plan for Small Incorporated Companies and Sole Proprietors that provides Insured Coverage with a “Pay-as-you-go” Health Spending Account!

Western LIFE ASSURANCE

www.CoreHealthPlus.com

NATIONAL HEALTHCLAIM CORPORATION

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Unplanned Expenses

Unplanned expenses can be a financial burden and require premium based insurance.

- Life Insurance
- Accidental Death & Dismemberment
- Critical Illness
- Travel Emergency Medical
- Excess Medical Costs

Routine Expenses

Why insure for all potential expenses when you can pay for only the expenses you actually incurred?

- Dental (Basic & Major)
- Orthodontics
- Prescription Drugs
- Paramedical Services
- Vision Care
- Physiotherapy
- Chiropractor

Insured Coverage

Monthly Premiums:
Single: $29.99 / Month
Family: $39.99 / Month

Insurance provided by
Western Life Assurance Company

Health Spending Account for Health and Dental Expenses

Pay-as-you-go, up to annual limits
The most tax-efficient way to pay for routine expenses
Administration provided by
National HealthClaim Corporation

The coreHEALTH+™ Plan Solution

Combines coverage for both types of expenses in a single plan.

Employee Group Insurance for Unplanned Expenses

- Low monthly premiums
- No medical underwriting
- Everyone is eligible
- Available to corporations with one or more employees

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Online Health Spending Account for Routine Expenses

- Pay-as-you-go with pre-tax money from your business
- For incorporated companies and sole proprietors
- A different annual limit can be set for different job classifications

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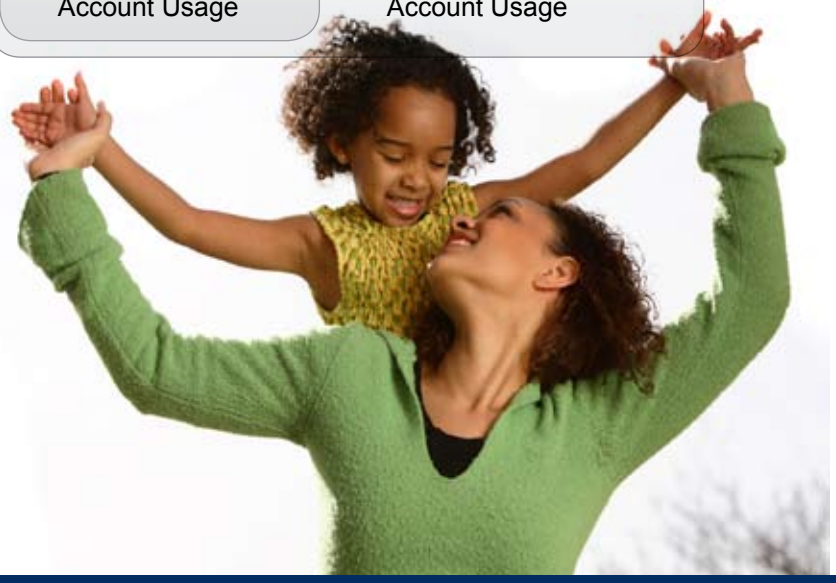
Plan Details

	Single	Family
Life Insurance	$15,000	$15,000 Employee $10,000 Spouse $5,000 per child
Accidental Death & Dismemberment	$60,000	$60,000 Employee
Critical Illness	$10,000	$10,000 Employee
Travel Emergency Medical For up to 60 days of travel	$1,000,000	$1,000,000 For each family member
Excess Medical Costs over $2,500	$250,000 Lifetime maximum	$250,000 Lifetime maximum
Premiums	**$29.99 / month** + Health Spending Account Usage	**$39.99 / month** + Health Spending Account Usage



How coreHEALTH+™ HSA Claims Are Reimbursed

1. Individual pays for medical expenses
2. Individual goes to the online claims website
3. HSA claim is submitted online
4. Notification sent to company admin
5. Company pays expenses and receives tax deduction
6. Reimbursement is sent to individual

Getting Started

Use the information below to complete your application

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My Company Is:

An Incorporated Company

A Sole Proprietor

Step 1

Complete **Part 1** of the enrollment form. Use the correct version for your company type.

Complete sections A & B, and be sure to read and sign the Authorization in section C.

Version A
Incorporated Company

Version B
Sole Proprietor

Step 2

Complete **Part 2** of the enrollment form.

Enter your employee data including spouse and dependant information in section D. If you need additional pages please copy and attach it to the application.

Step 3

Complete **Part 3** of the enrollment form.

Calculate the cost of your plan by completing sections E. Enter your banking details, and attach a VOID cheque to have your premiums automatically deducted.

Step 4

Mail or Fax your completed application form to National Health Claim Corporation.

National Health Claim Corporation
335 58th Ave S.E.
Calgary Alberta T2H 0P3
Fax: (403) 228-1580

Enrollment Form - Part 1
Version A: For Incorporated Company

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Policy #: _____
(For NHC use)

A Company Information

Legal Name of Company: _____ Phone: ( ) _____

Address: _____ Postal Code: _____

Plan Administrator: _____ Email: _____

Broker Name: _____ Email: _____

B Create Your Health Spending Account Plan (For yearly health & dental expenses)

Help

1. Choose the classifications for your company.
2. Please make sure the descriptions are accurate. Example text is shown below.
3. Enter the annual limit amounts. The grey amounts are defaults - any amount can be entered.
4. Consult the "Additional Information" page for details about Waiting Period and Pro-Rating

Select	Job Classification	Description	Annual Limit: Single	Annual Limit: Family	Waiting Period	Pro-Rated
☐ A	Executive	Has the authority to enter into contracts on behalf of the company and is responsible for the overall direction and vision of the company	$5,000	$10,000	30 d	Y / N
☐ B	Manager	Is responsible for all hiring and supervision of employees within their areas of responsibility	$1,000	$2,000	30 d	Y / N
☐ C	Full Time Employee	Performs daily operational duties and work for at least 30 hours a week	$1,000	$2,000	30 d	Y / N
☐ D	Other					Y / N

For additional descriptions please attach additional pages to this application.

Credit Carry Forward: (Choose an option)
- ☐ Use Credit Carry Forward
- ☐ Use Expense Carry Forward
- ☐ **DO NOT** Use Credit or Expense Forward

Credit Carry: Unused credits from one benefit year can transfer to the next year after the runoff period has ended.

Expense Carry: Expenses (receipts) from one benefit year can be claimed in the next year, after runoff period has ended (60 days).

No Carry: Credits must be used within each benefit year only.

Benefit Year:
- ☐ January to December
- ☐ Other: _____

The 12 month cycle that claims are made against

Effective Date of coreHEALTH+ : The first day of the month following the receipt of this application.

- ☐ Alternate Effective Date of Plan: ____/____ (MM / YYYY)
  Enter a date to make the plan effective on a future date.
- ☐ Alternate HSA Effective Date: ____/____ (MM/ YYYY)
  The Health Spending Account can be made (optionally) effective up to one year before the Plan Effective Date:

C Plan Authorization

By signing this enrollment form, the company agrees to provide the coreHEALTH+ plan for its employees and will pay for all premiums and HSA funding as required. This signature will also apply to the indemnity contract.

Signature of Authorized Company Officer: _____ Date: ____/____/____ (YYYY / MM / DD)

Print Name: _____

Please Fax or Mail Completed Application To:

National Health Claim Corporation
335 58th Ave S.E.
Calgary Alberta T2H 0P3
Fax: (403) 228-1580

Enrollment Form - Part 1
Version B: For Sole Proprietor

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Policy #: _____
(For NHC use)

A Company Information (Sole Proprietorship Only)

Legal Name of Company: _____ Phone: ( ) _____

Address: _____ Postal Code: _____

Plan Admin/Sole Proprietor _____ Email: _____

Broker Name: _____ Email: _____

B Create Your Health Spending Account Plan (For yearly health & dental expenses)

Help

1. Choose the classifications for your company.
2. Please make sure the descriptions are accurate. Example text is shown below.
3. Enter the annual limit amounts.
   The grey amounts are maximums established by the CRA - enter any amount up to the maximum of $1500.

Select	Job Classification	Description	Annual Limit: Single	Annual Limit: Family
☐ A	Self	The owner of the company	$1,500	$
☐ B	Employee	Performs daily operational duties and work for at least 15 hours a week	$	$
☐ C	Other			

For additional descriptions please attach additional pages to this application.

Calculate the maximum family limit by using the following formula:

$1500 (Self)
+
$1500 (Spouse)
+
$ 750 (for each child)

Enter any amount up to the maximum

Benefit Year:
☐ January to December — The 12 month cycle that claims are made against.
☐ Other: _____ — You can change the benefit year to match your fiscal year.

Effective Date of coreHEALTH+ : The first day of the month following the receipt of this application.

☐ Alternate Effective Date of Plan: ____/____ (MM / YYYY) — Enter a date to make the plan effective on a future date.

☐ Alternate HSA Effective Date: ____/____ (MM/ YYYY) — The Health Spending Account can be made (optionally) effective up to one year before the Plan Effective Date:

C Plan Authorization

By signing this enrollment form you are authorizing the placement of insurance coverage and the setup of a Health Spending Account for the Sole Proprietor (and it's employees if applicable), effective the first day of the next month. You also acknowledge that National HealthClaim recommends you seek professional accounting advice for the correct setup and expense deduction treatment of the coreHealth+ plan.

Signature of Sole Proprietor: _____ Date: ____/____/____ (YYYY / MM / DD)

Print Name: _____

Please Fax or Mail Completed Application To:

National Health Claim Corporation
335 58th Ave S.E.
Calgary Alberta T2H 0P3
Fax: (403) 228-1580

Enrollment Form - Part 2

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D Enter Your Employee & Dependent Information (All employees in the company must be enrolled)

Employee Information

Full Name: ______________________ Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D
(From Section B)

Date of Birth: ____ / ____ / ____
(YYYY / MM / DD)

Date of Hire: ____ / ____ / ____
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student*
	Spouse	/ /	
	Child	/ /	Y / N
	Child	/ /	Y / N
	Child	/ /	Y / N

Employee Information

Full Name: ______________________ Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D
(From Section B)

Date of Birth: ____ / ____ / ____
(YYYY / MM / DD)

Date of Hire: ____ / ____ / ____
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student*
	Spouse	/ /	
	Child	/ /	Y / N
	Child	/ /	Y / N
	Child	/ /	Y / N

Employee Information

Full Name: ______________________ Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D
(From Section B)

Date of Birth: ____ / ____ / ____
(YYYY / MM / DD)

Date of Hire: ____ / ____ / ____
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student*
	Spouse	/ /	
	Child	/ /	Y / N
	Child	/ /	Y / N
	Child	/ /	Y / N

* Students are eligible if they attend a post-secondary school full time and are 21-24 years old inclusive.
Dependents who are 20 years old or younger are automatically eligible.

For additional employees please attach additional pages.

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E Payment Information

The premiums for the insurance plan are paid monthly.
Calculate your premium below:

Number of **Single** Employees	_____	x $29.99 = $	_____
Number of **Family** Employees	_____	x $39.99 = $	_____
Sub Total		$	_____
Ontario Residents Add PST:		$	_____
Total Monthly Premium:		**$**	_____

F Monthly Debit Authorization Form

I (we) authorize National HealthClaim and noted Financial Institution to withdraw funds from my (our) business account for the purpose of paying coreHEALTH+ insurance premiums. A debit in paper, electronic or other form may be drawn on my (our) account beginning the 15th day of the month after the enrollment has been signed. I (we) will notify National HealthClaim in writing of any changes in the account information or cancellation of this authorization prior to the first day of the following month. I (we) also understand that should any withdrawal not clear my (our) account for reason of insufficient funds, National HealthClaim will automatically attempt to withdraw these funds within 10 days of the returned item without prior notification. I (we) authorize National HealthClaim to change the payment amount that will be indicated on an email statement sent the first day of the month after any plan changes (for the purpose of changing the number of employees or for annual premium changes). I (we) acknowledge that delivery of this authorization to National HealthClaim constitutes delivery by me (us) to the noted Financial Institution. This agreement may be cancelled by either me (us) or National HealthClaim in writing.

Name of Bank / Financial Institution: _____

I (we) authorize National HealthClaim to process a debit on the 15th day of each month for the amount indicated in section D.

Signature of Account Holder(s): _____

Print Name: _____

Date: _____ / _____ / _____
(YYYY / MM / DD)

****Please attach a VOID cheque to this application form to complete this authorization****

Additional Information

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Pre-Existing Condition Clause

A pre-existing exclusion applies to: Life insurance where less than 5 employees are enrolled, Travel Emergency Medical where less than 2 employees are enrolled, Excess Medical where less than 50 employees are enrolled, and Critical Illness insurance no matter how many employees are enrolled. No pre-existing exclusion applies to AD&D coverage. If an employee has a pre-existing condition, the exclusion is removed (ie. coverage is active) for Life, CI, and Excess Medical, after twenty-four (24) months of being on the Core-Health+ plan.

Excess Medical Costs

The covered benefits are accidental dental, prescription drugs, sera and vaccines, obtainable only upon a written prescription by a physician and dispensed by a pharmacist, semi-private hospital room differential, Nursing, Ambulance, Paramedical and Durable Equipment. There is a $2,500 deductible per calendar year per person under the program. After the deductible has been satisfied there is 100% coverage to a maximum payout of $25,000 per injury or sickness per person per calendar year with a maximum of $50,000 over 104 weeks and a lifetime maximum for all expenses of $250,000.

Administration Fee

An administration fee is charged on all Health Spending account claims. Applicable taxes are charged only on the administration fee. There are no plan set-up fees or additional charges.

Beneficiary

The designated beneficiary for the plan is the employee (or the sole propprietor), or the employee's estate. This cannot be changed.

Benefit Periods

All benefits are effective up to an including age 64 for employees and spouses except for coverage under the Health Spending Account which can continue for as long as employment continues.

Students are eligible if they attend a post secondary school full time and are 21 to 24 years old, inclusive. Dependents who are 20 years old or younger are automatically eligible.

Waiting Period and Pro-Rating

New employees can be limited in their initial use of the Health Spending Account portion of their coreHEALTH+ plan by using these two features. The Waiting Period is a time (30,60,90,180 days) that a new employee must wait after their hire date before any claims can be submitted. The Pro-rating feature will limit the annual HSA amount proportional to the number of months left in the benefit year. The Pro-rating feature begins after the Waiting Period (if applicable) has been satisfied.

Privacy Statement

Protecting the insured person's personal information at National HealthClaim Corp (NHC) and The Western Life Assurance Company (Western Life) is very important. We recognize and respect the individual's privacy. When a person applies for coverage, we establish a confidential file that contains their personal information. This file is kept in the offices of NHC and or Western Life. The insured person may exercise certain rights of access and rectification with respect to the information in their file by sending a request in writing to NHC or Western Life's address listed in the policy. We limit access to personal information in the insured person's file to NHC or Western Life staff that requires it to perform their duties, to persons to whom the insured person has granted access, and to persons authorized by law. We collect, use and disclose the personal information to process this application and, if this application is approved, provide and administer the insurance product(s) applied for, investigate and process claims, and create and maintain records concerning our relationship.

Disclaimer

This brochure contains only a general description of the policy contract issued by NHC and Western Life Assurance Company. While every effort has been made to ensure the accuracy of this brochure, your rights and benefits are governed by the contract or policy wording. Those governing documents will prevail if they differ from this brochure. Please visit www.corehealthplus.com for more plan details.

Cancellation Policy

Cancellation of this policy must be made in writing to National HealthClaim Corporation and will become effective the first day of the month following notice.

What Happens Next?

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1. The enrollment form, along with an attached VOID cheque, is sent to National HealthClaim for review and entry into their secure web application system. This information is also given to Western Life for their records.

2. An email will be sent to the company “Plan Administrator” with instructions for logging onto the coreHEALTH+ web site. Changes to the Plan / Employees can be done by the Plan Administrator through the web site and will become effective the first day of the following month.

3. An email will be sent to each individual with instructions for logging onto the coreHEALTH+ web site. Health Spending Account claims are made directly on the web site. A summary of the coreHEALTH+ benefits and coverage can also be viewed from the web site.

4. A Pre-Authorized debit for premiums will be made on the company bank account starting on the 15th day of the month following the enrollment form signing.

For more information visit us online at:

www.CoreHealthPlus.com
Toll Free: 1 866-342-5908
Email: info@nationalhealthclaim.com

Agent Information

NHC.CH 0923

Western LIFE ASSURANCE

NATIONAL HEALTHCLAIM CORPORATION