NORTHERN EMPLOYEE BENEFITS SERVICES | ᐅᑭᐅᓕᕐᓂᐊᕐᔪᓐᓇᖅᑐᓂᒃᑯᑐᖅ ᐃᑲᔪᓯᕐᒥᑦᑕᑎᒋᕐᓂᕐᒧᓐᓂᒃ ᐃᓱᒪᒋᔭᕐᓂᖅᑐᑦ
5122 53rd Street, Yellowknife NT, X1A 1V6
Ph: (867) 873-4965 Fax: (867) 873-5801

NEW EMPLOYER APPLICATION FOR PARTICIPATION IN THE NORTHERN EMPLOYEE BENEFITS SERVICES (NEBS) GROUP INSURANCE AND HEALTH BENEFITS PLAN

COMPLETE ALL PAGES AND MAIL ORIGINALS TO NEBS OFFICE (ADDRESS ABOVE)

Employer: _____

Mailing Address: _____

Telephone: _____ Fax: _____

We hereby apply to participate in the NEBS Insurance and Health Benefits Plan.

BASIC INSURANCE PLAN

To join the **NEBS Insurance and Health Benefits Plan you must participate in the four basic insurance plans:** Life Insurance, Accidental Death, Disease and Dismemberment Insurance, Dependent Life Insurance and Long Term Disability Insurance.

There are several Coverage Options for the Basic Insurance Plan.

Select one option per coverage listed:

LIFE INSURANCE

☐ 3X Annual base salary to a maximum of $300,000

☐ 1.5X Annual base salary to a maximum of $150,000

LONG TERM DISABILITY

☐ 60% of monthly earnings, less full CPP; non-taxable benefit; employee pays monthly premium; maximum monthly benefit $6,600

☐ 70% of monthly earnings, less full CPP; taxable benefit; cost-shared premium; maximum monthly benefit $6,600

NOTE: **ALL ELIGIBLE EMPLOYEES MUST PARTICIPATE IN THE FOUR BASIC INSURANCE PLANS AND THE OPTIONS YOU CHOOSE ABOVE.**

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OPTIONAL INSURANCE AND HEALTH BENEFITS PLANS

As an employer you have the option of participating in the following plans (check if selected):

☐ **SHORT TERM DISABILITY**

If you choose this plan your employees must participate.

If you choose this plan you have to select one of the following coverage options:

☐ 60% of weekly earnings; non-taxable benefit; maximum weekly benefit $1,535; employees must pay the premiums.

☐ 70% of weekly earnings; taxable benefit; maximum weekly benefit $1,535; employers may cost-share or pay the full premiums.

☐ **EXTENDED HEALTH CARE PLAN**

If you choose this plan **you must allow** your employees to have the choice of participating, which they must indicate on their personal Enrolment Form.

☐ **DENTAL CARE PLAN**

If you choose this plan **you must allow** your employees to have the choice of participating, which they must indicate on their personal Enrolment Form.

☐ **ELECTED AND APPOINTED OFFICIALS PLAN**

If you choose this plan all elected or appointed officials must participate.

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COST SHARING OF PREMIUMS

NEBS bills the employer monthly for the cost of the plans they have chosen for their employees and officials. Employers decide what share of costs each will pay and the employer is responsible for deducting from employees or officials their share of costs.

NEBS provides employers a monthly roll that details the cost for each employee and official and the cost-sharing between the employer and employee or official. To do this NEBS needs to know the cost-sharing you have with your employees or officials.

Please indicate cost-sharing:

	Employer %	Employee %
Life Insurance	_____	_____
Accidental Death, Disease & Dismemberment Insurance	_____	_____
Dependant Life Insurance	_____	_____
Long Term Disability Insurance*	_____	_____
Weekly Indemnity Insurance*	_____	_____
Extended Health Care Plan	_____	_____
Dental Care Plan	_____	_____
Elected and Appointed Officials Plan	_____	_____

***NOTE: IF YOU HAVE CHOSEN THE NON-TAXABLE BENEFITS OPTION THE EMPLOYEE MUST PAY 100% OF THE COSTS.**

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NEW EMPLOYEE WAITING PERIOD

You must choose one of the following options for the waiting period of all new employees hired after you become a NEBS member.

- ☐ 6 Months of employment waiting period
- ☐ 3 Months of employment waiting period
- ☐ No waiting period

NOTE: ALL CURRENT EMPLOYEES WILL BE ENROLLED ON THE EFFECTIVE DATE OF THE EMPLOYER'S MEMBERSHIP. ALL NEWLY ELECTED OR APPOINTED OFFICIALS WILL BE ENROLLED ON THE EFFECTIVE DATE OF ELECTION OR APPOINTMENT.

LIST OF ELIGIBLE EMPLOYEES AND OFFICIALS

You must complete and certify as accurate the attached list of all eligible employees and officials. All information is treated confidentially and will not be released to unauthorized persons.

You are allowed to designate a class or group of employees as eligible employees for certain plan coverage. In reviewing your application the Board will take careful review of any classification or grouping you may have established.

CHEQUE ENCLOSED

You are required to enclose a cheque for $50.00 made payable to the NEBS Group Insurance Fund.

This cheque will bind insurance coverage from the effective date until your first remittance is made.

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APPLICANT SIGNATURE

We attest this to be an approved application made on behalf of

Name of Organization

Requested Effective Date

In making this application we confirm we have read and agree to the terms of the NEBS Policy on Membership in NEBS and the NEBS Payment of Group Insurance and Health Benefits Premiums Policy.

Chief Elected/Appointed Official

Date

Chief Administrative Officer

Date

YOU WILL BE NOTIFIED OF THE STATUS OF YOUR APPLICATION WITHIN TWO WEEKS OF RECEIPT IN OUR CORPORATE OFFICE.

NEBS WILL ESTABLISH AN EFFECTIVE DATE OF YOUR MEMBERSHIP IN THE NEBS GROUP INSURANCE PLAN. THE BILLING FOR YOUR FIRST MONTH OF INSURANCE WILL BE SENT IN ADVANCE AND WILL BE DUE THE END OF THE FIRST MONTH OF EFFECTIVE PLAN COVERAGE.

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LIST OF ELIGIBLE EMPLOYEES AND OFFICIALS

Name of Employer: _____

Payroll Period: _____ Weekly _____ Bi-Weekly

_____ Semi-Monthly

List all current eligible employees that will be covered by the Group Insurance Plan upon the effective date of your membership with NEBS. List all current elected or appointed officials only if you have chosen this plan.

The employer must require and take all steps necessary to ensure all eligible employees enroll and participate in the plan coverage selected.

If you have a class or group of employees not included, or included for different coverage you must provide NEBS this detail at this time. Your application will be reviewed against any variation of eligible employees.

As an employer member of NEBS you are solely responsible for the on-going accuracy of your eligible employee and official lists. You agree to sign and return the NEBS monthly billing statements attesting to the accuracy of the employee list. As an employer member you are liable if you have not maintained an accurate, up to date eligible employee and official list with NEBS.

The attached list is certified to be a true list of all eligible employees as of the date below.

_____ _____

Chief Executive Officer Date

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Employee Listing (Attach a separate sheet if more space is required)

EMPLOYEE NAME	BIRTH DATE dd/mm/yyyy	SEX (M/F)	DEPENDANTS (YES OR NO)	POSITION TITLE	ANNUAL EARNINGS	MEMO/COMMENTS (CURRENTLY ON LEAVE, DISABILITY, ETC)

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Only complete if **Elected Official's** plan coverage has been selected. (Attach a separate sheet if more space is required)

OFFICIAL'S NAME	BIRTH DATE dd/mm/yyyy	SEX (M/F)	DEPENDANTS (YES OR NO)	DATE OF ELECTION/APPOINTMENT	CURRENT TERM ENDS ON	MEMO/COMMENTS