# OCCUPATIONAL ACCIDENT INSURANCE PROGRAM

## Occupational Accidental Death and Dismemberment

| | | |
|---|---|---|
| *Eligibility:* | All active clients/student(s) of the Policyholder / Employer, under the age of 65.<br>*Coverage terminates at the earlier of age 65 or retirement, whichever is earlier.* | |
| *Coverage:* | Accidental Death & Dismemberment, 24-hour business and pleasure.<br>All other benefits, Occupational Only. | |
| *Benefit Amounts:* | Accidental Death & Dismemberment | $150,000 |
| | Permanent Total Disability | $150,000 |
| | *Weekly Accident Indemnity* | |
| | Total 75% of gross weekly earnings to a max of $500 per week | |
| | Waiting Period: | 0 days |
| | Payable: | 52 weeks |
| | Accident Medical Treatment Expense | $10,000 |
| | Funeral Expense Benefit | $5,000 |
| *Loss Schedule:* | Sample wordings enclosed, including 200% paralysis | |
| *Exclusions:* | attached | |
| *Additional Benefits:* | Repatriation | $10,000 CAD |
| | Rehabilitation | $10,000 CAD |
| | Home Alteration & Vehicle Modification | $10,000 CAD |
| | Family Transportation | $10,000 CAD |

Broker Advantage Inc. 38 Victoria St S. Amherstburg ON N9V 2J8
Tel. 1-877-294-1810, Fax 1-519-736-9327

Coverage Starts: _____
Coverage Ends: _____

***Coverage will go into effect on our receipt of the application or your requested date, if later.***

## Employer Information

| | | |
|---|---|---|
| Employer's Name: | | |
| Type and Name of Business: | | |
| Address: | | |
| | | |
| Telephone Number: | | Fax: |
| Email: | | |

## Insured's Information (Employee)

| | | |
|---|---|---|
| Insured's Name: | | |
| Insured's Date of Birth: | | Sex: M ☐ F ☐ |
| Insured's Occupation: | | |
| Insured's Address: | | |
| | | |
| Insured's Telephone Number: | | |

**Term Requested**

- ☐ $660.00 12 month term
- ☐ $495.00 9 month term
- ☐ $330.00 6 month term
- ☐ $220.00 4 month term
- ☐ $165.00 3 month term
- ☐ $110.00 2 month term
- ☐ $ 61.00 1 month term

_____ Total Due

**Credit Card Information** ☐ Visa ☐ Mastercard

ACCOUNT NUMBER EXPIRY DATE

CARDHOLDER NAME CARDHOLDER SIGNATURE

*If you prefer to pay by cheque, please make your cheque payable to Broker Advantage Inc. NSF charges will be applied.*

## IMPORTANT NOTES:

1. Policy cancellations must be done in writing. You can fax your cancellation to 1-519-736-9327.
2. Additional insurance is available on a monthly basis if the insured stays on longer than the anticipated Term. To arrange additional insurance, please call 1-877-294-1810.
3. Prices are subject to change. Cancellation fee $25.00

EMPLOYER'S SIGNATURE DATE

INSURED'S SIGNATURE DATE

**FOR OFFICE USE ONLY:**

Certificate # _____ Enrolment Date:_____
Effective Date: _____ Termination Date: _____
Agent Name:_____ Agent Signature:_____ Agent # _____
Payment Information
Date: _____ Visa/MC Auth #: _____ Cheque Name: _____ #: _____

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# Privacy Consent Form

**Our sponsored and authorized agents and their employees may collect, use and disclose your personal information to assist in the servicing of new applications or in force policies or certificates and to maintain records of your previously issued applications and policies.**

**As part of our insurance services, your personal information will be used only to underwrite your policies, process your claims, ensure proper billing, service your accounts and offer you other products and services that we believe may suit your needs. It will be conveyed only to the applicable department of Broker Advantage Inc. and its authorized agency or servicing bureau and/or wholly owned subsidiary for servicing.**

**Your personal information will not be disclosed between our servicing departments, or to our agencies and bureaus or to other companies, without duly signed confidentiality agreements in force between these organizations.**

**Your personal information will be safeguarded and used only for the purposes referred to above.**

**By signing below, you consent to the collection, use and disclosure of your personal information as described above.**

**You can withdraw your consent in writing at any time after you have given it to us, so long as you give us thirty (30) days notice, but your doing so may mean that we can no longer provide you with products and services.**

**You have the right to request access to your personal information to verify its accuracy and completeness and to request amendments. Please submit your request in writing to our Privacy Officer, at 38 Victoria St S., Amherstburg, Ontario N9V 2J8 or call 1-877-294-1810.**

**We will be pleased to provide further information about your privacy rights. Questions and requests may be directed through your insurance producer, or to our Privacy Officer at Broker Advantage Inc.**

Dated this _____of_____,_____by_____.
Please Print Name

_____.
Name & Signature of Employee/Insured Authorizing Privacy Consent

Dated this _____of_____,_____by_____.
Please Print Name

_____.
Name & Signature of Policyholder/Employer Authorizing Privacy Consent

Witnessed this_____of_____,_____by_____.
Please Print Name

_____.
Name and Signature of Witness to Applicant

**CLIENT SIGNATURE REQUIRED**

CERTIFICATION: The attached statements are true and complete to the best of my knowledge and belief. In the event of a false or misleading statement my application and can be denied or coverage cancelled.

PERSONAL INFORMATION COLLECTION USE, AND EXCHANGE: The information I have provided in respect of this application for insurance will be forwarded to Sports-Can Insurance Managers Ltd., Special Risk International, who along with its authorized administrators, reinsurers, agents and adjusters (the "insurer") to assess my application for insurance, to evaluate and investigate claims, and to detect and prevent fraud. The Insurer shall also consult its existing files for these purposes.

AUTHORIZATION: Personal Information about me, my insurance premium payment and claims history may be sought by, and exchanged by the Insurer with other insurance companies, reinsurers, and industry organizations in connection with this application for insurance and any renewal, extension, variation or cancellation of any policy, if issued.

I consent to the collection, use and disclosure of my personal information as set out above.

_____ _____

Signature of Employee/Insured Signature of Employer/Policy Holder