canopy health insurance

APPLICATION AND ACCEPTANCE FORM

GROUP HEALTH INSURANCE

Name of Employer

Address of Employer

Name of Contact Person

Contact Number

Email Address

Coverage Effective Date

Probationary Period

Name of Brokerage

Name of Broker Representative

CATEGORY

PLAN OPTION SELECTED

Please confirm the options selected by placing a tick (√) in the applicable boxes:

Medical ☐ Dental/Optical combined ☐ Dental ☐ Optical ☐ OEMS ☐

INITIAL PREMIUM ESTIMATE

TIER	NO. OF PERSONS	MONTHLY PREMIUM RATE	TOTAL	GCT	TOTAL MONTHLY PREMIUM
Employee only					
Emp + 1 Dep.					
Emp + Family					
TOTALS		NOT APPLICABLE			

The following documents are to be attached: ☐ Company TRN ☐ Certificate of Incorporation ☐ Binder Premium

The abovenamed Employer hereby applies for Group Health Insurance benefits underwritten by Canopy Insurance Limited, to be extended to its employees and their eligible dependents.
The Employer accepts the benefit options and the corresponding premium rates, as outlined above and as per the attached schedule(s).The Employer further understands that the total amount of the Binder premium represents the initial premium which was derived from the data submitted on the membership listing, and any necessary adjustments will be presented on the initial invoice. Should there be a material difference between the data supplied and the actual enrollment at inception of the plan, Canopy reserves the right to adjust the monthly premiums accordingly.

Company Stamp

Authorized Signature

Print Name

Date