ADIUM
Insurance Services Inc.

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AMA HEALTH BENEFITS TRUST FUND

AMA Health Benefits Trust Fund Participation Agreement

If you have additional questions, please contact ADIUM Insurance Services at:

T 780.482.0692

TF 1.800.272.9680 ext. 692

F 780.488.7558

E-mail: adium@albertadoctors.org

Web Site: www.albertadoctors.org

An agreement between the AMA Health Benefits Trust Fund Trustees (the Trustees) and

_____

Physician (or corporation name if applicable)

I apply to participate in the extended health and dental plan(s) of the AMA Health Benefits Trust Fund (the Fund), effective from the first day of the month immediately following receipt and acceptance of this Participation Agreement and the Core Plan application form by the Fund Trustees.

I am applying within the following 60 day enrolment period (please check applicable space):

◯ January 1 to March 1 (Open Enrolment Period)

◯ Termination from another group insurance plan (please include the following details):

_____ _____

Termination Date Name of Plan/Employer

◯ Becoming a new member of the AMA

◯ Not applicable - I am already enrolled in the Fund

I choose to participate in the plan(s) as follows (check and initial either 1 or 2):

1. The Core Plan only ◯ (check) ____(initials)

   or

2. The Core Plan & Cost-Plus Plan ◯ (check) ____(initials)

   The administrator will set your Cost-Plus Plan Annual Dollar Liability Limit based on your family status as allowed by the Income Tax Act and Regulations for an Employee Life and Health Trust.

Please see the brochure for further information and consult with your tax advisor for complete details and restrictions

I elect to extend coverage to my eligible employees. ◯ Yes ◯ No ◯ Not Applicable
(If Yes, please complete the Employee Participation form at the back)

AMA Health Benefits Trust Fund Participation Agreement continued on next page.

For AMA Health Benefits Trust Fund Trustee use only.

_____

Authorized Signatory

_____

Date

By participating in the AMA Health Benefits Trust Fund, I agree that:

1. I am familiar with the terms and conditions of the Fund's extended health and dental plan(s) and the Fund's Trust Agreement.

2. I will abide by all terms and provisions of the plan(s), the Fund's Trust Agreement and the decisions of the Trustees.

3. I will pay the required Core Plan premiums, and if applicable Cost-Plus payments, on behalf of myself, my spouse, dependents and participating employees as designated on the Employee Participation form.

4. I understand that by extending health benefits to my eligible employees, all of my present and future eligible employees must participate in the plan. I confirm that all of my eligible employees are listed on the Employee Participation form. By not listing employees on the Employee Participation form, I confirm that I do not have
any eligible employees, or that I have elected not to extend the Fund's coverage to my employees.

5. I will promptly notify the Fund in writing should I choose to terminate employment of any participating employee, or if I employ new employees.

6. I am aware that upon approval by the Fund Trustees, this agreement will come into effect the first day of the month coincident with or next following the date of receipt of this Participation Agreement and the Core Plan application form. I understand the Fund Trustees may terminate this Participation Agreement by written notice to me. I agree to continue with the Fund until such date that the Fund Trustees process a written request of termination. I will send a request of termination by fax or mail to:

   Fax: 780.488.7558
   Email: adium@albertadoctors.org
   Mail: AMA Health Benefits Trust Fund
   Alberta Medical Association
   12230 106 Avenue NW
   Edmonton AB T5N 3Z1

In the event that either party changes address, written notice shall be given to the other party.

I understand that upon acceptance of this application by the Fund Trustees, it shall become a binding agreement in accordance with these terms and conditions and binds me and my personal representatives, estate and successors.

_____ _____

Physician signature (if an individual) Authorized signature (if a corporation)

_____ _____

AMA Number Date

AMA Health Benefits Trust Fund
Pre-Authorized Monthly Payment Authorization

Pre-authorized monthly payment is the only payment option available for Core Plan premiums.

Please attach a VOID cheque or insert the bank account information with respect to the account where the pre-authorized monthly payments are to be drawn from. Any cheque should be marked VOID (Send no money now). Also please sign on the line below to officially authorize monthly payments.

Name of account holder – must match name at top of page one

Name and address of your financial institution (street number and name)

Transit # | Institution # | Account #

Authorizing signature for pre-authorized monthly payments

Your coverage will begin on the first day of the month following the date your application is received and approved by the AMA Health Benefits Trust Fund.

AMA Health Benefits Trust Fund
Cost-Plus Plan Claim Reimbursement Electronic Funds Transfer Authorization

Please attach a VOID cheque or insert the bank account information of your PERSONAL bank account with respect to the account, if you wish to be reimbursed electronically. Also please sign on the line below to officially authorize.

Name of account holder

Name and address of your financial institution (street number and name)

Transit #

Institution #

Account #

Authorizing signature for reimbursement by EFT

AMA Health Benefits Trust Fund
Employee Participation Form

Please complete this form if you wish to provide health trust benefits to your employees. You may choose to provide Core Plan coverage only or Core Plan coverage plus Cost-Plus benefits to employees. If you choose to provide Cost-Plus benefits, please indicate the annual plan dollar liability limit for each employee.

If I have chosen to provide health benefits on a Cost-Plus basis to those employees listed below and any of my future eligible employees, then I agree with the Fund Trustees and with each of those employees that I will reimburse (and indemnify) those employees for the amount of any Cost-Plus benefits which are eligible for reimbursement ("Eligible Claims") plus pay an administration fee to the Fund, for so long as the employment contract of those employeesis in good standing. I agree that any liability of the Trust Fund to indemnify employees for Eligible Claims is limited solely to what I have deposited with the Trust Fund to pay Eligible Claims or which I have authorized the Trust Fund to pay from my designated bank account. I agree to indemnify the Trust Fund for any liability whatsoever for Eligible Claims. This agreement may be enforced by my present or future participating employees and by the Trustees.

Physician Name and Signature:

Participating Employees

Name: ______________________ Telephone: Home ____________ Work ____________

e-mail address: ______________________

Coverage: Core Plan Only ○ Core Plan and Cost-Plus Plan ○ Annual plan dollar liability limit $ ____________

Name: ______________________ Telephone: Home ____________ Work ____________

e-mail address: ______________________

Coverage: Core Plan Only ○ Core Plan and Cost-Plus Plan ○ Annual plan dollar liability limit $ ____________

Name: ______________________ Telephone: Home ____________ Work ____________

e-mail address: ______________________

Coverage: Core Plan Only ○ Core Plan and Cost-Plus Plan ○ Annual plan dollar liability limit $ ____________

Name: ______________________ Telephone: Home ____________ Work ____________

e-mail address: ______________________

Coverage: Core Plan Only ○ Core Plan and Cost-Plus Plan ○ Annual plan dollar liability limit $ ____________

Please make copies of this form and attach it to the application if more space is required.