MEDAVIE BLUE CROSS™

inConfidence®

APPLICATION/PROGRAM DOCUMENT FOR GROUPS UNDER 100 MEMBERS

SECTION A: APPLICATION INFORMATION

1 ☐ **NEW EFAP APPLICATION** ☐ **REVISION TO EXISTING EFAP**

2 **Date of Application:** _____ (yyyy-mm-dd) 3 **Program Effective Date:** _____ (yyyy-mm-dd)

SECTION B: COMPANY INFORMATION

4 **Company Name:**

5 **Company Alias(es):**
List other names the company may be referred to by its employees

1.	2.
3.	4.

6 **Industry Type:**
General Nature of Business

7 **Total number of employees eligible for EFAP:** _____

8 **When are new employees eligible for EFAP?** ☐ Immediately upon hire ☐ Upon expiry of Health Benefits Waiting Period

9 **What is the Health Benefits Waiting Period?** _____

10 **Are any classes of employees excluded from EFAP program (i.e. P/T, Casual, Retirees, etc.)?** ☐ N/A ☐ Yes, Specify Below

_____

11 **Primary EFAP Contact:**
Receives all initial communications, reports and invoices (unless otherwise specified)

Name:	Phone #:	
Email Address:		
Mailing address:		
City/Town:	Province:	Postal Code:

12 **Contact(s) for monthly promotions:**
List key contacts who will be able to distribute the material to internal audiences

Name:	Email Address:
Name:	Email Address:
Name:	Email Address:

13 **Contact for material shipments*:**
Complete ONLY if different than Primary EFAP Contact indicated above

All program materials will be delivered to the address indicated

Name:	Phone #:	
Email Address:		
Mailing Address:		
City/Town:	Province:	Postal Code:

*Shipping materials to a single location is included in the standard inConfidence program fees. Please ask for a quote if shipping to additional locations is required. If shipping to multiple locations is required, please attach the shipping contact information (name, phone and address) for each location along with material quantities by location.

14 **Initial Material Order Request - Allow 3 to 5 weeks for standard delivery**

	Quantity – English	Quantity – French	Quantity – Bilingual
☐ Brochures	_____	_____	N/A - Unilingual
☐ Clings/low tac stickers	_____	_____	N/A - Unilingual
☐ Posters (8.5”x11”)	N/A - Bilingual	N/A - Bilingual	_____
☐ Wallet Cards	N/A - Bilingual	N/A - Bilingual	_____

SECTION C: PROGRAM INFORMATION

inConfidence Toll Free Number: **1-877-418-2181**

inConfidence Website: **www.myinconfidence.ca**

15 **Username:** inconfidence **Password:** efap

enÉquilibre Website: **www.monenequilibre.ca**

16 **Username:** enequilibre **Password:** paef

17 **Critical Incident Stress Debriefing (i.e. "Trauma") Response:**
Is there any restriction on who can request trauma services? **(Note:** ***Medavie Blue Cross recommends choosing NO*****)** ☐ NO ☐ YES

18 If YES is selected, please provide the information on who can request trauma services :

Name:	Phone #:	Email:
Position:		

19 **Billing Method:**

☐ Monthly Invoice	The employee population recorded on system for the Plan Sponsor will be used. Plan Sponsor will be responsible for providing number of opt outs (if applicable).
☐ Self-Billed	Option available to select groups. At implementation, a self-billed excel template will be provided to the Plan Sponsor. Each month, the Plan Sponsor will complete the template, print the statement and return it (along with payment as per the instructions on the statement).

20 **Additional Comments:**

SECTION D: OTHER EMPLOYEE SUPPORTS AND BENEFITS (THIS SECTION IS OPTIONAL)

21 **Does the organization have a central contact in Human Resources or other department where employees can get information on company policies, procedures and guidelines?** ☐ **No** ☐ **Yes**

22 **If Yes, please provide:**

Contact Name:	Role:
Phone #:	Email Address:

23 **Please provide the phone number(s) employees can call if they have questions about other accessible benefits:**

Benefit Details	**Y**	**N**	**If different from above, include Contact Name and Phone #**
Health Risk Assessment	☐	☐	
Attendance Support Program	☐	☐	
Coverage for the services of a Psychologist	☐	☐	
Family/Personal Leave	☐	☐	
Substance Abuse Treatment Subsidy	☐	☐	
Others (specify):	☐	☐	

TO BE COMPLETED BY MEDAVIE BLUE CROSS

Account Executive:	Name:	Phone #:	Email:
Account Associate:	Name:	Phone #:	Email:
EFAP Representative:	Name:	Phone #:	Email:
Advisor/Consultant: ☐ N/A	Name:	Phone #:	Email:
	Company:		

Program Fees: Rate Per Employee/Per Month: _____

Total Number of Eligible Employees: _____

Total Monthly Premium: _____

Commission: ☐ YES ☐ NO

Commission rate: _____ **%**

Health and Dental RAD month, if applicable: _____

What administration system is being used? ☐ ES ☐ MAAX

Does this group have Mandatory Life Benefit? ☐ YES ☐ NO

(Total # of Employees) = **(# Enrolled in Health Benefits)** + **(# of Opt-outs and/or Employees eligible for EFAP only)***

******This number will only be updated on an annual basis.*

Comments:

SIGNATURE OF AUTHORIZED OFFICER

25 On behalf of the organization, I consent to the terms of Medavie Blue Cross' *inConfidence* Employee & Family Assistance Program.

Application is hereby made to MEDAVIE BLUE CROSS for the *inConfidence* EFAP described. We agree that no coverage will take effect until all of the following conditions have been met:

i. This application must be accepted and the effective date approved by MEDAVIE BLUE CROSS;
ii. Monthly fees apply to 100% of eligible participants. Pricing is based on the number of eligible employees (as detailed in Section B); but coverage is automatically extended to both the employees and their eligible dependents.

WE DECLARE that all statements, representations and answers made in this application are consideration for and a basis of the contract between us and MEDAVIE BLUE CROSS. We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of MEDAVIE BLUE CROSS. We agree to give MEDAVIE BLUE CROSS, on request, full information on each participant covered and eligible for coverage.

Print Name & Title of Authorized Officer::

Name:	Title:

Signed by Officer this:

Date: dd/mm/yy	Signature:

<END OF APPLICATION>