HEALTH SPENDING ACCOUNT ENROLMENT / CHANGE FORM

Employer / Plan Section (to be completed by the plan administrator)

Company Name: ____________________ Division: ____________ Policy No:____________

- ❑ **Enrol Employee (Plan effective date:_______________)**
- ❑ **Reinstate Employee (Plan effective date: ____________)**
- ❑ **Terminate Employee (Termination date : ____________)**
- ❑ **Add Dependant: (Effective date: ___________)**
- ❑ **Change Address**
- ❑ **Remove Dependant (Term. date: ___________)**

Employee/ Participant Details (to be completed by the employee)

Last Name:______________________ First Name:______________________ M/F:________

Street Address:____

City:______________________ Province:__________________ Postal Code:____________

Date of Birth: (mm/dd/yyyy):____________________ Daytime Phone Number: __________________

Coverage Status: Single: ________ Couple: ________ Family: ________ Waived: __________

Dependant Details (to be completed by the employee)

(mm/dd/yyyy)

Spouse: Last Name:_________________ First: ____________ Sex:_____ DOB:____________

Child 1: Last Name:_________________ First:____________ Sex:_____ DOB:____________

Child 2: Last Name:_________________ First:____________ Sex:_____ DOB:____________

Child 3: Last Name:_________________ First:____________ Sex:_____ DOB:____________

Child 4: Last Name:_________________ First:____________ Sex:_____ DOB:____________

Please indicate the name of any disabled dependants:_____________________________________

Please indicate below, if dependants are full time students and over age 21.

Attach the registration letter, which confirms full-time enrolment.

Name of Over Age Student	College/University Attended	Enrolled From	Enrolled To
__________________	________________________	________	________
__________________	________________________	________	________

Co-ordination of Benefits / Refusal of Coverage (to be completed by the employee)

If you and/or your dependants are presently insured for Health Care and/or Dental benefits under your spouse's group policy you may co-ordinate benefits or refuse coverage under this contract by completing the appropriate areas.

My spouse has coverage through __________________(insurance company) Policy no. ____________

- ❑ I wish to co-ordinate coverage with my spouse's plan Health ______ Dental ______ Vision ________
- ❑ I refuse insurance on myself and dependants under: Health ______ Dental ______ Vision ________

- ❑ I refuse insurance on my dependants under: Health _______ Dental _______ Vision ___________

***Please complete page 2 of this form, in its entirety.**

Electronic Funds Transfer

Branch Transit Number:____

Bank Code:____

Account Number:____

Bank Name:____

Signature (to be completed by the employee)

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

I understand that in the event of termination of employment or voluntary termination of plan participation I will not receive a refund of any unused Health Spending Account contributions.

Employee / Subscriber Signature:____

Employee / Subscriber Name (Please Print):____

Date:______________________________

For Plan Administrator Use

- ❑ Keep the original form for your records.