CORPORATE Health Spending Account Enrollment

Company

Name: ______________________________

Contact: ______________________________ Direct Phone: ______________________

Title: ______________________________ Fax: ______________________

EMail: ______________________________

Address: ______________________________ Main Phone: ______________________

____

City: ______________________________ Province: __________ Postal: ______________

Administration Fee

Administration Fee per claim: _______________%

Banking Information

Please provide void cheque or fill in information below:

Bank Number (3 digits): ________________

Transit Number (5 digits): ________________

Account Number: ________________

Company Administrator Contact Information

This person will receive an email with login information

Name ______________________________

Login Email ______________________________

Phone ______________________________

Address ______________________________

City ______________________________

Plan Design Options

1 - Plan Name (Employee Class): ____

2 - Plan Type: Regular Flex Plan

3 - Percentage of Coverage: 100% 80% 50% OTHER_________________

4 - Dollar Amount of Coverage Per Employee in Class: $_____________________

5 - Prefund Option: No Yes, Amount of Funding $___________

Frequency of Prefunding: Yearly Semi Annually Quarterly Monthly

6 - Employee Coverage Available to: Single (employee only) Family (Employee, Spouse, and dependents)

7 - Administration Fees to be paid by: Company Employee

8- Pick Expense List: General HSA claims (Incl. Extended Health Care, Dental, and Vision expenses)

Extended Health Care claims

Dental claims

Vision claims

9 - Pro-Rated type: Yearly Semi Annually Quarterly Monthly Daily

10 - Carry Forward (Unused benefits at the end of the benefit year): Forfeited Carried over to the next benefit year

11 - Start Date for Benefit Year (End date will be 1 year after): _____________________________

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