Tax Effective Private Health Care For Canadians

EMPLOYEE AMENDMENT

Contract Number: ______________________________

Amendment Type: ______________________________

** Please indicate if individual is an employee or dependent. Please list spouse and/or dependents immediately below the Eligible Members name

(this is only required if dependents are eligible to participate under The Health Plan).

Type "E" Emp "D" Dep	Class	First Name	Last Name	Init	Date of Birth (mm/dd/yy)	Sex (M/F)	Marital "S" Single "M" Married "D" Divorced "W" Widowed "C" Common-law

Please mail this Application to: The Health Plan Inc.,
P.O. Box 133, station "A"
Etobicoke, Ontario, M9C 4V2