

Application Form

Please Note: This application will form part of The Health Plan Agreement as Exhibit "A"

POLICYHOLDER

Name: _____ **Contract No:** _____ - _____ - _____

Legal Name: (if different) _____

Check One: Corporation Professional Corporation Self-Employed

MAILING ADDRESS

(address)

(city) (province) (postal code)

PHONE NUMBER

Telephone Number: (_____) _____ - _____ **Fax Number:** (_____) _____ - _____

OTHER INFORMATION

Fiscal Year End: _____ **The Health Plan Effective Date:** _____

Contact Person: _____ **E-Mail:** _____

BENEFIT PLAN PARAMETERS

Allowable Benefit Options

- All Eligible expenditures as described in the Income Tax Act, or (check one of more of the following)
 Dental Expenditures Prescription Drugs Only Vision Expenditures Only

Are Employees allowed to opt out of The Health Plan? Yes No

Are Employees allowed to opt back into The Health Plan? Yes No

Unused portions of the employee's annual maximum's can be rolled over for a maximum of one year? Yes No

Employees become eligible for benefits on 1st day of (select one)
 the 1st month following date of hire
 the 2nd month following date of hire
 the 3rd month following date of hire

Annual Benefit Plan Maximums

Employee Classifications	With Dependants	Without Dependants	%Co-Pay
Senior Executives	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Management	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Other Salaried	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Hourly	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Part Time	_____	_____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____

