The Health Plan INC

Tax Effective Private Health Care For Canadians

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	_____________	________________	[ ] No [ ] Yes _______
Management	_____________	________________	[ ] No [ ] Yes _______
Other Salaried	_____________	________________	[ ] No [ ] Yes _______
Hourly	_____________	________________	[ ] No [ ] Yes _______
Part Time	_____________	________________	[ ] No [ ] Yes _______

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EMPLOYEE INFORMATION

Total Number of Eligible Employees: _______________
Total Number of Participating Employees: _______________

** 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