# HEALTHCARE SPENDING ACCOUNT ENROLMENT / CHANGE FORM

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

Company Name: _____ Division: _____ Policy No: _____

| | |
|---|---|
| ❑ **New Plan Member**<br>**Date of Hire**<br>**(mmm/dd/yyy):** _____<br><br>❑ **Reinstate Plan Member**<br>**Date of Re-hire**<br>**(mmm/dd/yyy):** _____ | **Effective date of coverage**<br>**(mmm/dd/yyy):** _____ |
| ❑ **Terminate Plan Member**<br>**Termination date**<br>**(mmm/dd/yyy):** _____ | ❑ **Add Dependant:**<br>**Effective date of coverage**<br>**(mmm/dd/yyy):** _____ |
| ❑ **Change Address** | ❑ **Terminate Dependant**<br>**Termination date**<br>**(mmm/dd/yyy):** _____ |

**Plan Member Details**

Last Name: _____ First Name: _____ M/F: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (mmm/dd/yyyy): _____

Daytime Phone Number: _____ Email: _____

Coverage Status: Single: _____ Couple: _____ Family: _____ Waived: _____

**Dependant Details (to be completed by the plan member)**

(mmm/dd/yyy)

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: _____

Child 5: 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 |
|---|---|---|---|
| | | | |
| | | | |

***Complete page 2 of this form, in its entirety.**

## Co-ordination of Benefits / Refusal of Coverage (to be completed by the plan member)

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 _____

## Electronic Funds Transfer

Branch Transit Number (5 digits):_____

Bank Code (3 digits):_____

Account Number:_____

Bank Name:_____

## Signature (to be completed by the plan member)

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.

Plan Member / Subscriber Signature:_____

Employee / Subscriber Name (Please Print):_____

Date:_____

## For Plan Administrator Use

- ❑ Keep the original form for your records.