Health Spending Account

Employee Enrollment Form

A – MEMBER INFORMATION

Company Name

Last Name

First Name

Date of Birth (mm/dd/yy)

Gender ☐ Male ☐ Female

Street Address

Unit #

City/Town

Province

Postal Code

Home Phone #

Work Phone #

EXT

E-mail Address

B – DEPENDANT INFORMATION

A person related by blood/marriage or law and is financially dependent upon you.

Last Name	First Name	Relationship	Date of Birth (mm/dd/yy)	Gender (M/F)

C – EMPLOYEE ACKNOWLEDGMENT & SIGNATURE

- **I hereby acknowledge that all the information contained herein is accurate and truthful.**
- **I authorize Benecaid to contact any medical professionals on behalf of myself and my dependants to assist in resolving any queries Benecaid may have regarding claims that I or my dependants may submit.**
- **I understand that each reimbursement cheque is subject to a $3.75 processing fee, to be deducted from my HSA.**
- **Benecaid reserves the right to amend the processing fee, based upon administrative costs.**
- **Changes to this information will be submitted to Benecaid by fax (877-797-7449) on Benecaid's Employee Change Form.**

______________________________ ______________________________

Signature **Date** (mm/dd/yy)

(If applying for the Premiere Plan please fill out the Premiere Plan Medical Questionnaire)