



FOR OFFICE USE

HSA Account Number _____	# Cards _____
Company _____	

Employee Enrollment Form

EMPLOYEE INFORMATION

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Last Name First Name

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Street Number Street Name Unit Number

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City Province Postal Code

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Home Phone Number Business Phone Number

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email address

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Birthdate (mm/dd/yy) Social Insurance Number (necessary if purchasing insurance)

Have you been with this company longer than 3 months? Yes No

DEPENDANT INFORMATION (please print *clearly*)

Name	Birthdate (mm/dd/yy)	Relationship

EMPLOYEE ACKNOWLEDGEMENT

- I hereby acknowledge that all the information contained herein is accurate and truthful.
- Changes to this information will be submitted to Benecaïd by fax (905-823-7374) on a 'Move/Add/Change' Form
- I understand that each reimbursement cheque or Drug Card claim is subject to a \$3.75 processing fee, to be deducted from my HSA.
- Benecaïd reserves the right to amend the processing fee, based upon administrative costs
- I understand that I have access to a maximum of two additional months of HSA contributions – and that repayment will be deducted from the next two month's HSA contributions, plus a LOC fee of \$7.50 on every \$100 (one hundred dollars). Should my HSA be cancelled prior to the repayment of these credited contributions, I am personally responsible for their immediate repayment.
- As an Out of Country customer, I submit that I will not travel out of country:
 - a) Against my physician's medical advice, and/or
 - b) If I have been diagnosed with a terminal disease 12 months prior to departure
- I agree to allow my Social Insurance Number to act as my certificate number (if applicable)

Signature _____ Date _____