



Private Health Services Plan

EMPLOYEE ENROLLMENT FORM

Employee Name		Company Name	
Mailing Address			
City	Province	Postal Code	
Date of Birth (dd/mm/yy)			
Phone	Fax	Email	

EMPLOYEE DEPENDENT(S) INFORMATION

* **Dependent is defined as:** Your spouse (legal or common-law); your unmarried children (living at home) under 18, or under 25 if registered and attending as a full-time student at an educational institute; your children (of any age) who are incapable of supporting themselves due to a mental or physical disorder if the disorder begins before they turn 21 or while they are students under 25

Name of Dependent	Relationship	Date of Birth (dd/mm/yy)
1.		
2.		
3.		
4.		
5.		
6.		

I wish to participate in the **Tax Free Health Inc.** Private Health Services Plan and declare that the information above is correct.

Employee Signature: _____ Date: _____

THIS SECTION TO BE COMPLETED BY EMPLOYER

I, an authorized representative of the employer, hereby confirm that the above named employee is eligible under the terms of this employee health care plan and that the employee is entitled to be reimbursed for eligible medical expenses as herein described. Also, the undersigned agrees to notify **Tax Free Health Inc.** of any changes to the plan initiated by the employer.

I also understand that this program does not provide travel insurance. It is advisable and recommended that travel insurance be purchased any time that out of country travel is contemplated.

This program may involve elements of employee confidentiality. I have been informed and am aware of the implications of the freedom of information and privacy protection act.

For the above employee: -The EFFECTIVE DATE of the plan is (dd/mm/yy): ____ / ____ / ____
-The Annual Claim Limit is: \$ _____

I hereby confirm that the employee mentioned above is an eligible employee.

Employer Signature: _____ Date: _____