



*Private Health Services Plan*

EMPLOYEE OPT OUT FORM	
<b>PLEASE PRINT:</b>	
Company Name	
Employee Full Name	
Address	
Residence Telephone	
Business Telephone	
I HEREBY CERTIFY THAT I DO NOT WISH TO PARTICIPATE IN THIS PLAN AND HAVE ELECTED TO OPT OUT.	
Employee Signature:	Date:

***Tax Free Health Inc.***

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