Private Health Services Plan

Agent Referral Name: ______________________________

CLIENT ACCOUNT INFORMATION		
Legal Company Name		
Mailing Address		
City	Province	Postal Code
Main Contact Name		
Phone	Fax	Email

PLAN INFORMATION	
Company Fiscal Year End (dd/mm) ___/___	Effective Date of Plan (dd/mm/yy) ___/___ Effective date cannot be prior to the beginning of the company fiscal year. Effective date for all employees will commence on date noted above unless otherwise noted on Employee Enrollment Form.
Unused benefit to be: ☐ Rolled over for maximum of one Plan Year **OR** ☐ Forfeited at end of Plan Year	
No. of days after Plan Year end to file claims (there is a minimum 30 day grace period):	
Are benefits to be pro-rated for the 1st plan year? ☐ Yes ☐ No	
How do you wish to provide funding? ☐ Payment to be submitted with each claim ☐ Funds to be pre-deposited to a Trust Account	

ANNUAL CLAIM LIMITS				
A. Executive: $ ______________	**B.** Management: $ ______________	**C.** Full-time: $ ______________	**D.** Part-time: $ ______________	**E.** Other: $ ______________

EMPLOYEE CLASSIFICATION			
Employee Name	Class (A-E)	Annual Claim Limit	% Co-pay by employee*
		$	
		$	
		$	
		$	
		$	
		$	
		$	

*** % Co-pay will default to 0% (ie.100% employer paid) if not specified.**

No. of employees participating:	No. of employees opting out of program: An Opt-Out Form must be submitted for all full-time employees
New employees are eligible the 1st day of the ___ month following their hire date (e.g. 1st day of the 3rd month)	
Employees are not eligible for the Plan: ☐ upon termination **OR** ____ days after termination (specify no. of days)	
Note: Employer is responsible for notifying *Tax Free Health Inc.* when there are any employee changes	

SIGNATURE		
Applicant Name:	Applicant Signature:	Date: