CORPORATE APPLICATION

HEALTHCARE SPENDINGACCOUNT/WELLNESS

COMPANY INFORMATION

Company Name	
Contact	
Email Address	
Street Address	
City	
Province	
Postal Code	
Business No.	
Direct No.	

ADMINISTRATION FEE

Administration Fee per Claim	10	**%**

COMPANY ADMINISTRATOR INFORMATION

This person will receive an email with their login information, connected to the information needed below.

Administrator Name	
Email Address	
Direct No.	

Initial: _____

MYHSA PLAN DESIGN

1.	**Plan Name**	
	Class 1	
	Class 2	
	Class 3	
	Class 4	
2.	**Plan Type**	**Regular** **Flex** (taxable – Flex Plan Design page) (please select one)
3.	**Effective Date of Coverage**	
4.	**Percentage of Coverage**	**100%** **80%** **50%** **Other** (please select one)
5.	**Annual Allocation**	
	Class 1	
	Class 2	
	Class 3	
	Class 4	
6.	**Annual Allocation Pro-rated**	**Yes** **No** (please select one)
7.	**Pro-rated Type**	**Yearly** **Semi-annual** **Quarterly** **Monthly** (please select one)
8.	**Coverage Available to**	**Employee** **Family** (please select one)
9.	**Carry Forward**	**Forfeited** **Carried Forward** (please select one)

Initial: _____

FLEX PLAN DESIGN (taxable)

1.	**Plan Name**	
	Class 1	
	Class 2	
	Class 3	
	Class 4	
2.	**Plan Type**	**Taxable**
3.	**Effective Date of Coverage**	
4.	**Percentage of Coverage**	**100%** **80%** **50%** **Other** (please select one)
5.	**Annual Allocation**	
	Class 1	
	Class 2	
	Class 3	
	Class 4	
6.	**Annual Allocation Pro-rated**	**Yes** **No** (please select one)
7.	**Pro-rated Type**	**Yearly** **Semi-annual** **Quarterly** **Monthly** (please select one)
8.	**Coverage Available to**	**Employee** **Family** (please select one)
9.	**Carry Forward**	**Forfeited** **Carried Forward** (please select one)
10.	**Expense List**	**Daycare** **Personal Trainer** **Gym Fee/Membership**
		Fitness Equipment **Sporting Goods** **Continuing Education**
		Holistic Medicine **Public Transit**
		Other
		Other
		Other

Initial: _____

CORPORATION BANKING INFORMATION - AUTHORIZED WITHDRAWAL

Please attach a VOID cheque or complete the banking information below.

Bank Name	
Institution No.	
Transit No.	
Account No.	

ACKNOWLEDGEMENT AND CONSENT

I certify that all the information is true and complete and agree to the Acknowledge and Consent on the second page of this Employee Benefits Application form. I acknowledge that all other FWC Benefits Inc. coverage that I have in place will remain active.

Signature of Plan Contract Holder (required)	
Print Name of Plan Contract Holder (required)	
Date	

This consent is obtained in accordance with Alberta's Health Information Act, of Alberta's Personal Information Protection Act and the federal Personal Information Protection and Electronic Documents Act.

I certify that the information contained on this form (page 1 and 2) is true and complete. I understand that the personal information provided herein about me and eligible dependents, as well as other personal information currently held or collected in the future by FWC Benefits Inc., may be used or disclosed only to determine eligibility for benefits; verify, assess and pay claims; administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by my spouse and / or other adult dependents to disclose and receive information about them that is used solely for these purposes.

I hereby acknowledge and agree that my / my dependents' personal information may be exchanged between only FWC Benefits Inc. and a licensed physician and / or other health care professional, institution or health benefits provider or insurer or government or regulatory authority and only as needed for a purpose stated above.

I understand that my and my dependents' personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my / my dependents' personal information is needed and am aware of the risks and benefits of consenting or refusing consent to its use as described above.

I have read and understood this Acknowledgement and Consent and authorize FWC Benefits Inc. to collect, use and disclose my / my dependents' personal information as described above. This consent shall be effective from the date of signature of this form and shall remain in effect as long as the coverage is in force.