EMPLOYEE ENROLLMENT FORM

TO BE COMPLETED BY EMPLOYEE:

NAME OF EMPLOYER: _____

NAME OF EMPLOYEE: _____

DOB (DD/MM/YYYY):_____

TELEPHONE:_____

FAX: _____

E-MAIL: _____

HOME ADDRESS:

STREET: _____

CITY: _____

PROVINCE: _____

POSTAL CODE: _____

DEPENDENTS:

1. NAME: _____

   RELATIONSHIP:_____

   BIRTHDATE: _____

2. NAME: _____

   RELATIONSHIP: _____

   BIRTHDATE: _____

3. NAME: _____

   RELATIONSHIP: _____

   BIRTHDATE: _____

4. NAME: _____

   RELATIONSHIP: _____

   BIRTHDATE: _____

I, _____ WISH TO PARTICIPATE IN THE EMPLOYEE HEALTH CARE PLAN AND DECLARE THAT THE ABOVE INFORMATION IS CORRECT.

EMPLOYEE SIGNATURE: _____

DATE: _____

1 Note: It is the responsibility of the insured/employee to ensure that all claims comply with and meet CRA guidelines. We strongly recommend consulting an accounting professional to determine the eligibility of your claim.

EMPLOYEE ENROLLMENT FORM

TO BE COMPLETED BY EMPLOYER:

CODE	EMPLOYEE CLASSIFICATION	SINGLE	FAMILY
1	EXECUTIVE	$ _____	$ _____
2	MANAGEMENT	$ _____	$ _____
3	FULL-TIME EMPLOYEES	$ _____	$ _____
4	PART-TIME EMPLOYEES	$ _____	$ _____
5	HOURLY	$ _____	$ _____
6	Other: _____	$ _____	$ _____

*As the Employer you will need to determine the amount of money each Employee in each class of employment is eligible for in a given year. **For each Employee, circle the corresponding classification code and indicate the eligible amount in the chart above.**

I, _____ (EMPLOYER) CONFIRM THAT _____ _____ (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. THE UNDERSIGNED AGREES TO NOTIFY **PROFMED PHSP ADMINISTRATORS INC.** OF ANY CHANGES TO THE PLAN.

COVERAGE DOES NOT INCLUDE ANY FORM OF TRAVEL INSURANCE. IT IS RECOMMENDED THAT TRAVEL COVERAGE IS ALSO OBTAINED.

FOR THE ABOVE EMPLOYEE THE **EFFECTIVE DATE** OF THE PLAN IS

DAY: _____

MONTH: _____

YEAR: _____

EMPLOYER SIGNATURE: _____

Note: It is the responsibility of the insured/employee to ensure that all claims comply with and meet CRA guidelines. We strongly recommend consulting an accounting professional to determine the eligibility of your claim.

EMPLOYEE ENROLLMENT FORM

INSTRUCTIONS AND DEFINITONS

Instructions:

Employee to complete and sign page 1

Employer to complete and sign page 2

Dependents:

Dependents are classified as follows:

1. A spouse legally married to you or publicly represented as your spouse or partner.
2. Children under 18 years of age.
3. Children 18 years of age or older who are attending full time school.
4. Children, regardless of age, who are infirm or have a disability.
5. Parents who are dependent on their adult children for their care.

It is the responsibility of the Employee to inform **ProfMed PHSP Administrators Inc.** of any changes to dependency status.

Employer Section:

This section must be consistent with the Group Application Form.

Effective date:

The effective date of the plan is to be determined by the employer and can never be prior to the effective date as indicated on the client account information form.

Note: It is the responsibility of the insured/employee to ensure that all claims comply with and meet CRA guidelines. We strongly recommend consulting an accounting professional to determine the eligibility of your claim.