benecaid®

HSA Employee Enrolment Form

Benecaid Office Use Only	
Member ID	
HSA Eff.	YYYY MM DD
HSA Complete Eff.	YYYY MM DD
Travel Assist Eff.	YYYY MM DD

Plan Administrator: Please complete and sign section 1 and pass onto the employee. Submit to Benecaid when forms are complete.
Employee: Complete sections 2 - 4 and sign section 5. Pass this form onto your Plan Administrator. If applying for hsa*complete*™, an hsa*complete*™ Employee Enrolment Form must be completed and submitted along with this enrolment.

1. ADMINISTRATOR

Company Name: | Group Number:

☐ New Application
☐ Re-instatement

HSA Effective Date: YYYY MM DD

Net HSA Contribution and Period: $

Employer Sponsored Products:
☑ HSA Complete Single ☑ HSA Complete Couple ☑ HSA Complete Family
☑ Travel Assist Single ☑ Travel Assist Family

Plan Administrator Name: | Signature: | Date Signed: YYYY MM DD

2. EMPLOYEE INFO

Last Name: | First Name: | Gender: ☑ Male ☑ Female | Date of Birth: YYYY MM DD

Street Address: | Unit #: | PO Box:

City: | Province: | Postal Code:

Telephone: | Email:

3. DEPENDENTS

Relationship*	Last Name	First Name	Date of Birth	Gender M / F
			YYYY MM DD	
			YYYY MM DD	
			YYYY MM DD	
			YYYY MM DD	

* A person related by blood/marriage or law who is financially dependent upon you. Common-law spouses must have resided with you for the past 12 consecutive months.

4. DIRECT DEPOSIT FOR CLAIMS

To ensure accuracy, one of the following is required to set-up direct deposit for claims reimbursement:

- Physical cheque marked "VOID"
- Legible photocopy of a cheque marked "VOID"
- Legible fax/scan of a cheque marked "VOID"

If you have a savings account, please have your financial institution complete the information below:

Name of Financial Institution: | Teller Stamp:

Financial Institution Code: (3 digits)

Branch Number: (5 digits)

Account Number: (up to 12 digits)

5. SIGNATURE

- **Use of Your Information**: The insurance you are applying for, or have been provided with, is underwritten by an insurer (the "Insurer") and is administered by Benecaid Health Benefit Solutions Inc. ("Benecaid"). You agree that Benecaid and the Insurer may collect, use and disclose your information as described in the enclosed Privacy Agreement. You agree that you will only provide information about your spouse or your dependent children, if each of them have authorized you to do so, and if each of them have consented to the collection, use and disclosure of his or her information as described in the enclosed Privacy Agreement. **Certification:** You certify the information you have provided is true, correct and to the best of your knowledge. **Communication:** You consent to Benecaid communicating with you via email. **Copies:** You agree that a photocopy or electronic copy of this section is as valid as the original.
- I understand that each reimbursement is subject to a $3.75 processing fee, to be deducted from my HSA.
- I understand that my Health Spending Account is subject to a $95 annual account fee that will be charged each calendar year.
- Benecaid reserves the right to amend the processing fee based upon administrative costs.
- I understand that my banking information is used solely for the purpose of depositing Benecaid HSA claim reimbursements into my account.
- I understand that any changes in banking information must be provided to Benecaid to maintain the HSA direct deposit service.
- I hereby authorize Benecaid Health Benefit Solutions Inc. to deposit my HSA claim reimbursements in Canadian dollars to the bank account above until such time that I provide a written request to change this information.

Name: | Signature: | Date Signed: YYYY MM DD

HSA Employee Enrolment Form Cont...

(Employee Name: _____)

6. PRIVACY AGREEMENT

In this Agreement, the words “you” and “your” mean any person who has requested from us, applied for, or is insured under any product or service offered, insured, reinsured, administered or sold by us. The words “we”, “us” and “our” mean

(1) Benecaid Health Benefit Solutions Inc. and Benecaid Insurance Solutions Inc. (collectively "Benecaid") and any affiliates of Benecaid. (2) any insurance company that insures your personal accident, sickness, life, travel, dental or other coverage provided through Benecaid; (3) any company that will in future provide coverage that replaces all or part of the insurance coverage listed in (2) or any other insurance currently provided through Benecaid; (4) any company that provides reinsurance to any company listed in (1) through (3); and (5) service providers for any company listed in (1) through (4).

The word “Information” means personal, health-related, financial and other details about you that you provide to us and we obtain from others outside our organization, including through the products and services you use.

You acknowledge, authorize and agree as follows:

COLLECTING YOUR INFORMATION

At the time you begin a relationship with us and during the course of our relationship, we may collect Information directly by us, or through our representatives, including:

- details about you and your background, including your name, address, date of birth, occupation and other identification, all of which are required under law;
- information you provide through the application and claims process for any of our insurance products or services; and
- information for the provision of insurance products and services.

This Information may be collected from you and from sources outside our organization, including from:

- government agencies and registries, law enforcement authorities and public records;
- any healthcare professional, medically-related facility, insurance company, or other person who has knowledge of; your information
- other service providers, agents, brokers and other organizations with whom you make arrangements; other insurance companies;
- your employer; references you have provided; and
- persons authorized to act on your behalf under a power of attorney or other legal authority.

You authorize those sources to give us the Information.

USING YOUR PERSONAL INFORMATION

This information may be used for the following purposes:

- to administer your insurance and your trust accounts (if any); to communicate with you;
- to verify your identity and investigate your personal background; to investigate, adjudicate, manage and coordinate your claims;
- to arrange and maintain insurance products and other services you may request; to help us better manage our business and your relationship with us;
- to evaluate and underwrite insurance risk, re-price medical expenses and negotiate payment of claims expenses;
- to better understand your insurance situation; to offer you products and services to meet your needs; to determine your eligibility for insurance and non-insurance products and services we offer;
- to detect and prevent fraud;
- to compile statistics; to help us better understand the current and future needs of our clients; and
- as required or permitted by law.

DISCLOSING YOUR INFORMATION

We may disclose your Information, including as follows:

- to other insurance companies, other financial institutions and health organizations;
- to any health-care professional, medically-related facility, insurance company or other person who has knowledge of your personal Information; to appropriate public health authorities.
- to administrators, service providers, reinsurers and prospective insurers and reinsurers of our insurance operations, as well as their administrators and service providers for these purposes;
- in response to a court order, search warrant or other demand or request, which we believe to be valid;
- to meet requests for information from regulators, including self-regulatory organizations of which we are a member or participant, to satisfy legal and regulatory requirements applicable to us;
- to our employees, suppliers, agents and other organizations that perform services for you or for us or on our behalf;
- when we buy or sell all or part of our businesses or when considering such transactions;
- to help us collect a debt or enforce an obligation owed to us by you; and
- where permitted by law.

Telephone discussions – When speaking with one of our telephone service representatives, we may monitor and/or record your telephone discussions for our mutual protection, to enhance customer service and to confirm our discussions with you.

MORE INFORMATION

Personal information or personal health information may be collected, used, disclosed, transferred, stored or processed outside of Canada and may therefore be subject to legal requirements in such foreign countries. Full details regarding how your privacy is protected can be obtained by asking us for a copy of our Privacy Policy.

Please read our Privacy Policy for further details about this Agreement and our privacy policies. Visit **www.benecaid.com** or contact us for a copy.

You acknowledge that we may amend this Agreement and our Privacy Policy from time to time to reflect changes in legislation or other issues that may arise. We will post the revised Agreement and Privacy Policy on our website listed above. You acknowledge, authorize and agree to be bound by such amendments.

If you wish to opt-out or withdraw your consent at any time for any of the opt-out choices described in this Agreement, you may do so by contacting us at: **1-877-797-7448**. Please read our Privacy Policy for further details about your opt-out choices.

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HSA Employee Enrolment Form
Instructions & Notes

Section 1. Administrator

Net HSA Contribution and Period: Enter the amount of money contributed per period (monthly, quarterly, semi-annually, annually) to the employee prior to admin fees and taxes being added.

Employer Sponsored Product: Choose the product(s) that your company is paying for the product(s) over and above the HSA contribution. Employees may choose to purchase these products on their own using their HSA if the wish.

Note: Contribution periods are based on the company anniversary date. If the employee's contribution period is quarterly, semi-annual or annual and the HSA effective date for the employee falls in the middle of a contribution period, you should prorate the deposit cheque for the remainder of the current contribution period. Subsequent payments will be for the full contribution period.

Section 2. Employee Info

Email: This is the email address Benecaid will use for general communication and for direct deposit notifications.

Section 3. Dependents

HSA Complete and Travel Assist Applicants: If you are applying for family hsa*complete*™ or family travel*assist*® and you have a dependent child age 21 - 25 you must provide proof of paid full-time student status at an Institute of Higher Learning for claims to be considered. Complete and return the Over-Age Dependent Eligibility Declaration Form to Benecaid which must be submitted each year/term.

If you have a dependent child age 21 and older who is mentally or physically disabled you must submit documentation from a medical practitioner confirming the disability for claims to be considered.

Section 4. Direct Deposit for Claims

Banking Information Change: If you fail to notify Benecaid of a change to your direct deposit banking information causing a claim reimbursement to be rejected by the bank, a bank processing fee will be charged to your Health Spending Account to set up new direct deposit banking information.

Section 5. Signature

Processing Fee: There is a $3.75 processing fee attached to each reimbursement cheque or direct deposit issued to you. The fee is not per claim but per cheque or direct deposit, meaning that if more than one claim is submitted at a time only $3.75 is deducted from your Health Spending Account.

Submission

Mail: 185 The West Mall, Suite 800, Toronto, ON M9C 5L5
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