

Please send completed forms to:

Kechnie Benefits

447 Frederick Street, 4th Floor Kitchener ON N2H N2P4 T: 519 571-2020 | 866 710-7080 F: 519 571-2424 | 866 710-7888

Employer Group Benefit Plan Application

Section A - Employer Information

Plan Sponsor	Contact Person		Contact Person & Title/Occupation			
·						
Address (number,street,apt. number)		City		vince	Postal Code	
Email Address		Phone Number		Fax Number		
Section B - Optional Program(s)						
In addition to the Group Benefit Program, will y	ou be establishii	ng a Health Care Sp	ending A	ccou	nt?	
YES - Please send me an Employer Enrolment Application for the Health Care Spending Account.NO						
Section C - Payment Mode Selection:						
 Pre-Authorized Debit – Complete the attached Pre-Authorized Debit form. Receive Electronic Delivery of Invoices – Complete the contact email address the invoice will be sent to: 						
User Account:		-				
(name) Section D - Policy Holder Signature	(title)	(eı	nail ad	idress)	
Name (Please Print Clearly)	Titl	e				
Signature			Date	 ≥ Signed	d (dd/mm/yyyy)	
By signing this application we hereby request all <u>eligible members</u> be insured for benefits. If the Insurer accepts this application, the coverage will become effective on the date indicated. We understand that a policy will be issued and will contain, among other items, the Insurers' usual clauses, to the extent that they do not conflict with the Insurer's submission and any subsequent agreements. We acknowledge and understand that our policy will be administered through Kechnie Benefits. We confirm that the information contained in the Application for Group Insurance and the subsequent employee Enrolment Form(s) is true and agree that any false declaration on our part or <u>anti-selection</u> against the insurer constitutes grounds for a denial of claim and/or the cancellation of the contract. We agree to submit, without delay, any request for insurance from an eligible person, and to provide all necessary information (including annual payroll updates) for the sound administration of the Policy. We understand and accept our responsibility to not only notify the administrator about these change, but to pay the premium calculated using the approved rates in a timely manner.						
For Kechnie Office Use Only:						
Date Received: Date Processed:	Administrator Init	tials:				