Please send completed forms to:

Kechnie Benefits
447 Frederick St., 4th Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

Employer Application - Health Care Spending Account

Part A - Employer Information

Plan Sponsor	**Effective Date**	Contact Person	Contact Person's Title
Address (number,street,apt. number)	City	Province	Postal Code
Email Address	Phone Number	Fax Number	

Part B - Divisions/Class

Division/Class	Funding for Division/Class	Reimbursement Level	Description of Division/Class

Please note you may elect to offer different funding for family/single members within the same class, or separate funding for members in different classes. (Example: Family $500/yr, Single $250/yr)

Part C - Plan Information

Pro-Rate Credits:

- ❑ Monthly
- ❑ Annually (Employees will be given their entire year's allotment at the beginning of each year)

At the end of the plan year:

- ❑ Claims Rollover (Claims from previous year can be paid in the next year)
- ❑ Credit Rollover (Money left over from previous year can be used in the next year)

Effective Date of Plan: _____

Part D - Summary of Fees

- ❑ Plan set up fee: $
- ❑ Annual fee: $
- ❑ Adjudication fee: 10%; min $10 / max $250 per paid claim
- ❑ Initial Contribution: _____

Part E - Method of Payment (Invoices are mailed on a monthly basis)

- ❑ Pre Authorized Debit (PAD). (We recommend pre-authorized debit in order to withdraw funds on the 15th of every month.) Please complete, sign and attach a void cheque to the attached PAD form.
- ❑ Cheque

Part F - Policy Holder Signature

I hereby apply for a Health Care Spending Account issued by Kechnie Benefits and accept the financial liabilities outlined to us by Kechnie Benefits. I certify that the information in this form is true and complete to the best of my knowledge.

Name (Please Print Clearly)	Title
Signature	Date Signed (dd/mm/yyyy)

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Administrator Initials:_____