

Health Care Spending Account Employee Enrollment Application

Section A-Plan Sponsor Information

Company Name		Plan Administrator's Name		
Employment Date (dd/mm/yyyy)	Class	Effective Date of Coverage (dd/mm/yyyy)	First Time Enrolling in this Plan? <input type="radio"/> Yes <input type="radio"/> No	Waive Waiting Period? <input type="radio"/> Yes <input type="radio"/> No

Section B- Plan Member Information

First Name	Last Name	Middle Name(s)	Date Of Birth (dd/mm/yyyy)
Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Common Law → Co-habitation Status Effective Date: _____		Sex <input type="radio"/> Male <input type="radio"/> Female	Home Phone Number ())
Address (number,street,apt. number)		City	Province Postal Code

Section C- Group Coverage (Please indicate your level of coverage under your group benefit plan)

Health	Dental	Type of Coverage
		Single Coverage
		Family Coverage
		None, because my spouse has coverage (You must complete section D)

Section D- Coordination of Benefits (Please indicate the level of coverage your spouse has under his/her group benefit plan)

Health	Dental	Type of Coverage	Carrier Information
		Single Coverage (your spouse only)	Name of Carrier: _____
		Family coverage (your whole family)	Effective date: _____

Section E- Family Information

Dependent's Full Name	Date of Birth (dd/mm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)
Spouse			
Child			
Child			
Child			

Section F- Plan Member Signature

I certify that the information in this form is true and complete, to the best of my knowledge. I am authorized to release information concerning my spouse and my dependents (if applicable), for the purposes of determining their eligibility for benefits.

Plan Member Signature	Date Signed (dd/mm/yyyy)
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For Kechnie Office Use Only:

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