VITAL HEALTH SAVINGS PLAN

Employee Enrolment/Change Form

Plan Sponsor:		ASO Acct No.
☐ New employee ☐ Change ☐ Termination	Effective Date:	
Administrator's Signature:	Date	Agent ID (VHSP Use Only)

EMPLOYEE INFORMATION

Name	Date of Birth (dd/mm/yyyy)	Male or Female

HOME ADDRESS

Street	City	Prov	Postal Code

PHONE		**EMAIL ADDRESS**
Office	Home	

PLAN COVERAGE

Employee Class _____	Annual Salary _____
☐ Single ☐ Couple ☐ Family	No. of Dependants _____

Dependants Last name	First name	Date of Birth dd/mm/yyyy

SUMMARY OF BENEFIT PLAN SPECIFICATIONS

Please transfer summary information from overleaf.

For Agent or Office Use Only

Health Care Coverage

HEALTH INSURANCE POLICY	☐ SSQ ☐ Other	
TOTAL ESTIMATED OUT-OF-POCKET HEALTH COSTS	A	
Benefit Choices		
TOTAL COST OF SELECTED BENEFITS	B	
EST. EXCESS/(SHORTFALL)	C	
Flex-Credit Allocation		
Benefits	D	
Additional Cash Salary	E	
TOTAL FLEX-CREDITS	F	

REIMBURSEMENT

Claims may be reimbursed by cheque payable to the Employee at the address above or by deposit directly to the Employee's bank account specified below. Please attach a copy of a void cheque.

Name of Bank or Institution	FI Code ___	Branch Transit # _____	Account Number
Employee Signature	**Date**		PHSP Acct No

VHSP Use Only	Date Rec'd and Logged	Recorded ☐ ASO Rec. ____ ☐ PHSP C/F____ ☐ QB____ ☐ Ins____	Checked: *(Initials & Date)*

Please ensure this form is signed and dated.

Mail to: Vital Health Savings Plan
112 – 42 Industrial St
Toronto ON M4G 1Y9

OR

Fax to: Vital Health Savings Plan
416-498-8004

Telephone: 416-696-1864 *Website: www.vitalbenefitplan.com* *Email: kkremer@vitalbenefitplan.com*

Health Care Coverage

Excess Medical & Emergency Travel insurance			EMPLOYEE ANNUAL COST
☐ SSQ	SPECIFY: ☐ Single ☐ Couple ☐ Family	**PAID BY:** ☐ Employer ☐ HCSA	
☐ Covered under another Policy:	☐ Spouse's Group Plan	☐ Other _____	

Needs Analysis for Family Health Care	Please fill in net out-of-pocket health cost estimates, i.e. after reimbursement from insurance claims				
Expenses For:	**Member**	**Spouse**	**Child(ren)**		**Total – All Family**
Drugs					
Dental					
Dental Major – Crown, Bridges, Orthodontist.					
Vision					
Massage, Chiro, Accupuncture					
Other					
TOTAL EST. OUT-OF-POCKET HEALTH COSTS				**A**	**$**

Benefit Choices

	Coverage Amount	**Monthly Cost**		**Annual Cost**
Vital Health Care Spending Account • Covers all medical/ dental costs recognized by Canada Revenue Agency • 100% re-imbursement of all claims up to account limit • Plan member selects desired amount of coverage.				
Disability Insurance • Monthly income for employee who is disabled and cannot work • Available in multiples of $100 /mo. on pre-tax or after-tax basis				
Long Term Care Insurance • Provides a monthly indemnity for facility care or home care if insured is physically dependent or cognitively impaired. • Level of benefit selected from $500 to $10,000 /mo. (multiples of $100)				
Life Insurance • Inexpensive term insurance to cover employee and family members				
TOTAL COST OF SELECTED BENEFITS			**B**	
Subtract: Employer Benefit $$ Contribution				
ESTIMATED EXCESS/(SHORTFALL)	Flex-Credits can be used to meet any shortfall		**C**	**$**

Flex- Credit Allocation

		Allocated To		**Annual $$ Allocated**
FLEX CREDITS PROVIDED? ☐ Y ☐ N	AMOUNT:$_____	Benefits	**D**	
Total Flex-Credits Allocated should equal Total Flex-Credit Amount provided. Any unallocated balance will be directed to Additional Cash Salary.		Additional Cash Salary	**E**	
	TOTAL FLEX-CREDITS ALLOCATED		**F**	