

Enrollment Form



Policy # _____
(NHC Use)

A Company Information

Legal Name of Company: _____ Phone: (____) _____
 Address: _____ City: _____
 Province: _____ Postal Code: _____
 Company Plan Administrator: _____ Email: _____
 Broker Name: _____ Broker Email: _____

B Health Spending Account - Plan Details (See section E for additional information)

- i** 1. Choose job classification(s) for the employees of your company. It is required that each employee within a classification be extended the same annual limits.
 2. Please make sure the descriptions are accurate. Example text is shown below.
 3. Enter the annual limit amounts. The grey amounts are default - any amount can be entered.

	JOB CLASSIFICATION	JOB DESCRIPTION	ANNUAL LIMIT SINGLE	ANNUAL LIMIT FAMILY
A	Executive	Has the authority to enter into contracts on behalf of the company and is responsible for the overall direction and vision.	\$5,000	\$10,000
B	Manager	Is responsible for all hiring and supervision of employees within their areas of responsibility.	\$1,000	\$2,000
C	Full Time Employee	Performs daily operational duties and work for at least 30 hours a week.	\$750	\$1,500
D	Other			
E	Other			

C Enter Your Employee & Dependent Information

EMPLOYEE INFORMATION			
Full Name: _____		Email: _____ <small>(This will be used as the website username)</small>	
Job Classification: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <small>(From Section B)</small>		Date of Birth: _____ <small>(YYYY / MM / DD)</small>	
Date of Hire: _____ <small>(YYYY / MM / DD)</small>			
Dependents			
Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
_____	Spouse	_____	
_____	Child	_____	Y / N
_____	Child	_____	Y / N
_____	Child	_____	Y / N

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Additional Employees (Attach additional pages for more employees - there is no limit)

EMPLOYEE INFORMATION			
Full Name: _____		Email: _____ <small>(This will be used as the website username)</small>	
Job Classification: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <small>(From Section B)</small>		Date of Birth: _____ <small>(YYYY / MM / DD)</small>	
Date of Hire: _____ <small>(YYYY / MM / DD)</small>			
Dependents			
Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
_____	Spouse	_____	
_____	Child	_____	Y / N
_____	Child	_____	Y / N
_____	Child	_____	Y / N

EMPLOYEE INFORMATION			
Full Name: _____		Email: _____ <small>(This will be used as the website username)</small>	
Job Classification: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <small>(From Section B)</small>		Date of Birth: _____ <small>(YYYY / MM / DD)</small>	
Date of Hire: _____ <small>(YYYY / MM / DD)</small>			
Dependents			
Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
_____	Spouse	_____	
_____	Child	_____	Y / N
_____	Child	_____	Y / N
_____	Child	_____	Y / N

EMPLOYEE INFORMATION			
Full Name: _____		Email: _____ <small>(This will be used as the website username)</small>	
Job Classification: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <small>(From Section B)</small>		Date of Birth: _____ <small>(YYYY / MM / DD)</small>	
Date of Hire: _____ <small>(YYYY / MM / DD)</small>			
Dependents			
Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
_____	Spouse	_____	
_____	Child	_____	Y / N
_____	Child	_____	Y / N
_____	Child	_____	Y / N

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D Authorization and Indemnity Contract

By signing this enrollment form, the company agrees to provide a healthcare spending account for its employees and will pay for all account funding and administration fees as required.

This signature will also apply to the indemnity contract.

Signature of Authorized
Company Officer: _____
(YYYY / MM / DD)

Date: _____

Print Name: _____

Please Mail Enrollment Form and \$300 + GST to: National Health Claim Corporation (519 HSA)
335 58th Ave S.E.
Calgary, Alberta,
T2H 0P3

E Additional Information

Plan Effective Date and Benefit Year

The effective date for the company Health Spending Account is immediate upon receipt of enrollment form. The “benefit year”, which runs from Jan 1 to Dec 31, is the 12 month period that claims can be made. An alternate effective date (past or future) or alternate benefit year cycle can be accommodated if requested.

Other Plan Options

The 519Plan HSA program can accommodate other advanced plan features such as: Credit Carry Forward and Pro-rating / Waiting Period for new hires. Contact National HealthClaim to set up these options.

HSA Funding

A company can choose to provide funding for their HSA by either “Pay-as-you-go” (generate a cheque for each expense claim submitted) or by “Pre-funding”. To utilize the “Pre-funding” method, a company is required to send in a block of money that will be held in an account and drawn from as HSA claims come in. By “Pre-funding” an account, claims will be processed immediately. All HSA accounts will operate in either mode, automatically. NHC does not pay interest on monies held.

Privacy Statement

Protecting the insured person’s personal information at National HealthClaim Corp. (NHC) is very important. We recognize and respect the company and individual’s privacy. When a company enrolls for an HSA, we establish a confidential file that contains their account and employee information. This file is kept in the offices of NHC. We collect and use the personal information to process this enrollment and provide and administer the financial product(s) enrolled for, investigate and process claims, and create and maintain records concerning our relationship.

What Happens Next?

- 1** The signed enrollment form is sent to National HealthClaim for review and entry into their secure web application system. NHC may contact the company Plan Administrator to discuss the enrollment if there are questions. It is important that the Plan Administrator indicate their email address on the enrollment form.
- 2** An email will be sent to the company “Plan Administrator” with instructions for logging onto the 519Plan HSA web site. Changes to the Plan / Employees can be done directly by the Plan Administrator through the web site.
- 3** An email will be sent to each employee with instructions for logging onto the 519Plan HSA web site. Claims are made directly on the web site. The employee username for the login is the email address submitted on the enrollment form and must be unique to each employee.