

Enrollment Form

Policy #: _____
(For NHC use)

A Company Information

Legal Name of Company: _____ Phone: (____) _____

Address: _____ Postal Code: _____

Plan Administrator: _____ Email: _____

Broker Name: _____ Email: _____

Broker ID: _____ Association: _____

B Create Your Health Spending Account Plan (For yearly health & dental expenses)



1. Choose the classifications for your company.
2. Please make sure the descriptions are accurate. Example text is shown below.
3. Enter the annual limit amounts. The grey amounts are defaults - any amount can be entered.
4. Consult the "Additional Information" page for details about Waiting Period and Pro-Rating

Select	Job Classification	Description	Annual Limit: Single	Annual Limit: Family	Waiting Period	Pro-Rated
<input type="checkbox"/> A	Executive	Has the authority to enter into contracts on behalf of the company and is responsible for the overall direction and vision of the company	\$5,000	\$10,000	30 d	Y / N
<input type="checkbox"/> B	Manager	Is responsible for all hiring and supervision of employees within their areas of responsibility	\$1,000	\$2,000	30 d	Y / N
<input type="checkbox"/> C	Full Time Employee	Performs daily operational duties and work for at least 30 hours a week	\$1,000	\$2,000	30 d	Y / N
<input type="checkbox"/> D	Other					Y / N

For additional descriptions please attach additional pages to this application.

Credit Carry Forward: Use Credit Carry Forward Unused claim amounts / credits can be carried into the next benefit year for a maximum of 2 years
 DO NOT Use Credit Carry Forward

Benefit Year: January to December The 12 month cycle that claims are made against
 Other: _____

Effective Date of coreHEALTH+: The first day of the month following the receipt of this application.

To make the plan effective on a future date, enter:

Alternate Effective Date of Plan: ____/____/____
(MM / YYYY)

The Health Spending Account can be made (optionally) effective up to one year before the Plan Effective Date:

Alternate HSA Effective Date: ____/____/____
(MM / YYYY)



Enter Your Employee & Dependent Information (All employees in the company must be enrolled)

Employee Information			
Full Name: _____		Email: _____ <small>(This will be used as the website username)</small>	
Job Classification: _____ <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: _____ <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: _____ <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

* Students are eligible if they attend a post-secondary school full time and are 21-24 years old inclusive. Dependents who are 20 years old or younger are automatically eligible.

For additional employees please attach additional pages.

D Payment Information

The premiums for the small business group insurance are paid monthly.
Calculate your premium below:

Number of Single Employees	_____	x \$29.99 = \$	_____
Number of Family Employees	_____	x \$39.99 = \$	_____
.....			
Sub Total		\$	_____
Ontario Residents Add PST:		\$	_____
Total Monthly Premium:		\$	_____

E Monthly Debit Authorization Form

I (we) authorize National HealthClaim and noted Financial Institution to withdraw funds from my (our) business account for the purpose of paying coreHEALTH+ insurance premiums. A debit in paper, electronic or other form may be drawn on my (our) account beginning the 15th day of the month after the enrollment has been signed. I (we) will notify National HealthClaim in writing of any changes in the account information or termination of this authorization prior to the next withdrawal date of the pre-authorization payment. I (we) also understand that should any withdrawal not clear my (our) account for reason of insufficient funds, National HealthClaim will automatically attempt to withdraw these funds within 10 days of the returned item without prior notification. I (we) authorize National HealthClaim to change the payment amount that will be indicated on an email statement sent the first day of the month after any plan changes (for the purpose of changing the number of employees or for annual premium changes). I (we) acknowledge that delivery of this authorization to National HealthClaim constitutes delivery by me (us) to the noted Financial Institution. This agreement may be cancelled by either me (us) or National HealthClaim in writing.

Name of Bank / Financial Institution: _____

I (we) authorize National HealthClaim to process a debit on the 15th day of each month for the amount indicated in section D.

Signature of Account Holder(s): _____

Print Name: _____

Date: _____ / _____ / _____
(YYYY / MM / DD)

****Please attach a VOID cheque to this application form to complete this authorization****

F Authorization

By signing this enrollment form, the company agrees to provide the coreHEALTH+ plan for its employees and will pay for all premiums and HSA funding as required. This signature will also apply to the indemnity contract.

Signature of Authorized
Company Officer: _____

Date: _____ / _____ / _____
(YYYY / MM / DD)

Print Name: _____

Please Fax or Mail To: National Health Claim Corporation
335 58th Ave S.E.
Calgary Alberta T2H 0P3
Fax: (403) 228-1580

Pre-Existing Condition Clause

Benefits (Life, AD&D, Critical Illness, Excessive medical costs and Travel emergency medical) are not payable as a result of any pre-existing condition unless death, critical illness, travel emergency medical expenses or excessive medical costs commences after the employee has been continuously insured for twenty-four (24) months after the effective date of insurance.

Pre-existing conditions means any injury, sickness, mental illness, nervous disorder or any other condition for which medical advice, consultation, diagnosis or treatment was required or recommended by a Physician, or for which a reasonable person would have sought treatment or advice, during the twenty-four months (24) prior to the effective date of insurance.

First Occurrence Clause

This is a clause in relation to Critical Illness coverage only. It states that only the first occurrence of a critical illness will be paid from this policy. If, for example, an employee had cancer before coverage was effective then the Critical Illness coverage would not pay out for cancer. The policy would however pay out for any other qualifying Critical illness.

Excess Medical Costs

The covered benefits are accidental dental, prescription drugs, sera and vaccines, obtainable only upon a written prescription by a physician and dispensed by a pharmacist. There is a \$5,000 deductible per person under the program. After the deductible has been satisfied there is 100% coverage to a maximum payout of \$25,000 per year with a lifetime maximum of \$75,000.

Administration Fee

An administration fee is charged on all Health Spending account claims. Applicable taxes are charged only on the administration fee. There are no plan set-up fees or additional charges.

Beneficiary

The designated beneficiary for the plan is the employee or the employee's estate. This cannot be changed.

Benefit Periods

All benefits are effective up to an including age 64 for employees and spouses except for coverage under the Health Spending Account which can continue for as long as employment continues.

Students are eligible if they attend a post secondary school full time and are 21 to 24 years old, inclusive. Dependents who are 20 years old or younger are automatically eligible.

Waiting Period and Pro-Rating

New employees can be limited in their initial use of the Health Spending Account portion of their coreHEALTH+ plan by using these two features. The Waiting Period is a time (30,60,90,180 days) that a new employee must wait after their hire date before any claims can be submitted. The Pro-rating feature will limit the annual HSA amount proportional to the number of months left in the benefit year. The Pro-rating feature begins after the Waiting Period (if applicable) has been satisfied.

Privacy Statement

Protecting the insured person's personal information at National HealthClaim Corp (NHC) and The Western Life Assurance Company (Western Life) is very important. We recognize and respect the individual's privacy. When a person applies for coverage, we establish a confidential file that contains their personal information. This file is kept in the offices of NHC and or Western Life. The insured person may exercise certain rights of access and rectification with respect to the information in their file by sending a request in writing to NHC or Western Life's address listed in the policy. We limit access to personal information in the insured person's file to NHC or Western Life staff that requires it to perform their duties, to persons to whom the insured person has granted access, and to persons authorized by law. We collect, use and disclose the personal information to process this application and, if this application is approved, provide and administer the financial product(s) applied for, investigate and process claims, and create and maintain records concerning our relationship.

Disclaimer

This brochure contains only a general description of the policy contract issued by NHC and Western Life Assurance Company. While every effort has been made to ensure the accuracy of this brochure, your rights and benefits are governed by the contract or policy wording. Those governing documents will prevail if they differ from this brochure. Please read the full policy for all plan details and coverage.