

HSA Employee Enrollment Form



Benecaid Office Use Only	
Client ID	
HSA Eff.	YYYY MM DD
HSA Complete Eff.	YYYY MM DD
Travel Assist Eff.	YYYY MM DD

Plan Administrator: Please complete and sign section 1 and pass onto the employee. Submit to Benecaid when forms are complete.
Employee: Complete sections 2 - 4 and sign section 5. Pass this form onto your Plan Administrator. If applying for *hsacomplete™*, an *hsacomplete™* Application must be completed and submitted along with this application.

1. ADMINISTRATOR	Company Name:		Group Policy #:	
	<input type="checkbox"/> New Application <input type="checkbox"/> Re-instatement		HSA Effective Date: YYYY MM DD	Net HSA Contribution and Period: \$
	Employer Sponsored Products:	<input type="checkbox"/> HSA Complete Single <input type="checkbox"/> HSA Complete Couple <input type="checkbox"/> HSA Complete Family	<input type="checkbox"/> Travel Assist Single <input type="checkbox"/> Travel Assist Family	
	Plan Administrator Name:		Signature:	Date Signed: YYYY MM DD

2. EMPLOYEE INFO	Last Name:		First Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: YYYY MM DD
	Street Address:				Unit #:	PO Box:
	City:			Province:		Postal Code:
	Telephone:		Email:			

3. DEPENDENTS	Relationship*	Last Name	First Name	Date of Birth	Gender M / F
				YYYY MM DD	
				YYYY MM DD	
				YYYY MM DD	
				YYYY MM DD	

* A person related by blood/marriage or law who is financially dependent upon you. Common-law spouses must have resided with you for the past 12 consecutive months.

4. DIRECT DEPOSIT FOR CLAIMS	To ensure accuracy, one of the following is required to set-up direct deposit for claims reimbursement:	
	<ul style="list-style-type: none"> Physical cheque marked "VOID" Legible photocopy of a cheque marked "VOID" Legible fax/scan of a cheque marked "VOID" If you have a savings account, please have your financial institution complete the information below:	
	Name of Financial Institution:	Teller Stamp:
	Financial Institution Code: (3 digits)	
Branch Number: (5 digits)		
Account Number: (up to 12 digits)		

5. SIGNATURE	I hereby acknowledge that all information contained herein is accurate and truthful. I authorize Benecaid to contact any medical professionals on behalf of myself and my dependents to assist in resolving any queries Benecaid may have regarding claims that I or my dependents may submit. I authorize Benecaid to communicate with me by email regarding products and services related to my Health Spending Account. I understand that each reimbursement is subject to a \$3.75 processing fee, to be deducted from my HSA. Benecaid reserves the right to amend the processing fee based upon administrative costs. I understand that my banking information is used solely for the purpose of depositing Benecaid HSA claim reimbursements into my account. I understand that any changes in banking information must be provided to Benecaid to maintain the HSA direct deposit service. I hereby authorize Benecaid Health Benefit Solutions Inc. to deposit my HSA claim reimbursements in Canadian dollars to the bank account above until such time that I provide a written request to change this information.		
	Name:	Signature:	Date Signed: YYYY MM DD



HSA Employee Enrollment Form Instructions & Notes

Section 1. Administrator

Net HSA Contribution and Period: Enter the amount of money contributed per period (monthly, quarterly, semi-annually, annually) to the employee prior to admin fees and taxes being added.

Employer Sponsored Product: Choose the product(s) that your company is paying for the product(s) over and above the HSA contribution. Employees may choose to purchase these products on their own using their HSA if the wish.

Note: Contribution periods are based on the company anniversary date. If the employee's contribution period is quarterly, semi-annual or annual and the HSA effective date for the employee falls in the middle of a contribution period, you should prorate the deposit cheque for the remainder of the current contribution period. Subsequent payments will be for the full contribution period.

Section 2. Employee Info

Email: This is the email address Benecaid will use for general communication and for direct deposit notifications.

Section 3. Dependents

HSA Complete and Travel Assist Applicants: If you are applying for family *hsacomplete*TM or family *travelassist*[®] and you have a dependent child age 21 - 25 you must provide proof of paid full-time student status at an Institute of Higher Learning for claims to be considered. Proof can be in one of two forms: 1) A letter from the registrar stating full-time status for the current term or year 2) an invoice showing full-time student status with the current term or year paid in full.

If you have a dependent child age 21 and older who is mentally or physically disabled you must submit documentation from a medical practitioner confirming the disability for claims to be considered.

Section 4. Direct Deposit for Claims

Banking Information Change: If you fail to notify Benecaid of a change to your direct deposit banking information causing a claim reimbursement to be rejected by the bank, a bank processing fee will be charged to your Health Spending Account to set up new direct deposit banking information.

Section 5. Signature

Processing Fee: There is a \$3.75 processing fee attached to each reimbursement cheque or direct deposit issued to you. The fee is not per claim but per cheque or direct deposit, meaning that if more than one claim is submitted at a time only \$3.75 is deducted from your Health Spending Account.