Health Assist
4550 Highway 7, Suite 225
Vaughan, Ontario L4L 4Y7

HEALTH assist

# Employee Application / Change Form for Spending Account

- ❑ Enrolment Form — Date of Hire / Re-Hire: ______________
- ❑ Change Form — Type of Change: ____________________ — Date Effective: ____________

## Employer / Plan Section (to be completed by the plan administrator)

Company Name: ______________________________________________ Policy No: _________________

## Employee / Participant Details (to be completed by the employee)

Last Name: _________________________________ First Name: ________________________________ M/F: ___________

Address: _______________________________________________________________________________________________

_______________________________________________________________________________________________________

SIN (Certificate No.): _________________________________ Date of Birth: (mm/dd/yyyy): __________

Marital Status: ______________________________________ Coverage Status: Single: _____ Family: ________

## Dependent Details (to be completed by the employee)

Spouse: Last Name: ________________ First: ___________ Sex: ____ DOB: _____________________

Child 1: Last Name: ________________ First: ___________ Sex: ____ DOB: _____________________

Child 2: Last Name: ________________ First: ___________ Sex: ____ DOB: _____________________

Child 3: Last Name: ________________ First: ___________ Sex: ____ DOB: _____________________

Child 4: Last Name: ________________ First: ___________ Sex: ____ DOB: _____________________

**Please indicate below if any of your dependents are full time students over age 21**

| Name of Over Age Student | College/University Attended | Enrolled From | Enrolled To |
|---|---|---|---|
| | | | |
| | | | |

Please indicate the name of any disabled dependents: ___________________________________________________________

## Authorization (to be completed by the employee)

By enrolling in this plan I am authorizing the applicable insurance carriers, agents and service providers to use and exchange information collected in this form to underwrite, administer and adjudicate claims. I also authorize my plan sponsor to use this same information for benefits administration and to make any necessary payroll deductions, which may be required.

Employee / Participant Signature: ________________________________________________

Employee / Participant Name (Please Print): ________________________________________

Date: ______________________________