

Employee Enrollment - Health Care Spending Account

Section A-Employer information

Company Name	Group Number	Certificate Number	Division	Class
Date Of Full Time Employment (dd/mmm/yyyy)	Regular Hours/Week	Employee's Title/Occupation		

Section B- Employee information

First Name	Last Name	Middle Name(s)	Date Of Birth (dd/mmm/yyyy)
☐ Single ☐ Married ☐ Common-Law: Date of Cohabitation _____ ☐ Separated ☐ Divorced ☐ Widowed		Sex ☐ Male ☐ Female	Language of Preference ☐ English ☐ French
Home Phone Number ()			
Address (number,street,apt. number)		City	Province
Postal Code			
Email Address (optional)			

Section C- Spouses Health & Dental Coverage

(If your spouse does **not** have his or her **own** coverage this section does not apply)

Health	Dental	
		Your Spouse ONLY
		Your spouse and yourself only
		Your spouse and children only
		Your spouse, you and your children

Name of Carrier: _____
Effective date: _____

Section D- Family Information

Dependent's Full Name	Date of Birth (dd/mmm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)	Full-Time Student? (Yes or No) If yes, name accredited institution
Spouse				
Child				
Child				
Child				
Child				

Section E- Plan Member Signature

I hereby apply for a Health Care Spending account issued by Kechnie Benefits. I certify that the information in this form is true and complete, to the best of my knowledge.

Plan Member Signature	Date Signed (dd/mmm/yyyy)
-----------------------	---------------------------