

Health Care Spending Account Application

Company Name: _____ Policy No. _____ Division No. _____ SIN #: _____

Employee Name: _____ Home Address: _____
(First Name) (Last Name) (Postal Code)

Date of Hire: _____ Hours worked per week: _____ Male Female Date of Birth: _____
(Month/Day/Year) (Month/Day/Year)

Do you have a spouse/common-law spouse? Yes No Name: _____ Date of Birth: _____ Male Female

Do you have dependent children? Yes No Name: _____ DOB: _____ M F Disabled
(Educational Institution)

Name: _____ DOB: _____ M F Disabled
(Educational Institution)

Name: _____ DOB: _____ M F Disabled
(Educational Institution)

Name: _____ DOB: _____ M F Disabled
(Educational Institution)

If overage dependent children are between the ages of 21 & 25 and are attending school Full-Time, please make sure you fill in their Educational Institution.

BENEFIT COVERAGE:

I elect the following coverage:

Spending Account: Single
Family
Waived

Are you and/or your spouse covered by any other group insurance plan? Yes No If yes please circle: Health S F Dental S F Vision S F

If yes, name of Other Insurance Company: _____

Policy Number: _____ ID Number: _____

I hereby apply for a Health Care Spending Account issued by Kechnie Benefits and authorize the deduction from my pay of any contributions I must make towards the cost of this account. I authorize the use of my Social Insurance Number where it is required for the purpose of benefits administration.

Employee Signature: _____

Date: _____

Kechnie Benefits
262 Queen Street South
Kitchener, ON N2G 1W3

