KECHNIE BENEFITS

Please send completed forms to:

Kechnie Benefits
447 Frederick St., 4th Floor
Kitchener ON N2H 2P4
T: 519 571-2020 | 866 710-7080
F: 519 571-2424 | 866 710-7888

Health Care Spending Account Employee Enrollment Application

Section A-Plan Sponsor Information

Company Name		Plan Administrator's Name		
Employment Date (dd/mm/yyyy)	Class	Effective Date of Coverage (dd/mm/yyyy)	First Time Enrolling in this Plan? ◯ Yes ◯ No	Waive Waiting Period? ◯ Yes ◯ No

Section B- Plan Member Information

First Name	Last Name	Middle Name(s)	Date Of Birth (dd/mm/yyyy)
Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Separated ◯ Divorced ◯ Common Law → Co-habitation Status Effective Date: _____		Sex ◯ Male ◯ Female	Home Phone Number
Address (number,street,apt. number)	City	Province	Postal Code

Section C- Group Coverage (Please indicate your level of coverage under your group benefit plan)

Health	Dental	Type of Coverage
☐	☐	Single Coverage
☐	☐	Family Coverage
☐	☐	**None**, because my spouse has coverage **(You must complete section D)**

Section D- Coordination of Benefits (Please indicate the level of coverage your spouse has under his/her group benefit plan)

Health	Dental	Type of Coverage	Carrier Information
☐	☐	Single Coverage (your spouse only)	Name of Carrier: _____
☐	☐	Family coverage (your whole family)	Effective date: _____

Section E- Family Information

Dependent's Full Name	Date of Birth (dd/mm/yyyy)	Sex (M or F)	Disabled Dependent? (Yes or No)
Spouse			
Child			
Child			
Child			

Section F- Plan Member Signature

I certify that the information in this form is true and complete, to the best of my knowledge. I am authorized to release information concerning my spouse and my dependents (if applicable), for the purposes of determining their eligibility for benefits.

Plan Member Signature	Date Signed (dd/mm/yyyy)

For Kechnie Office Use Only:

Date Received:_____ Date Processed: _____ Administrator Initials:_____