FBC HEALTH SPENDING ACCOUNT

FBC HSA : Enrollment Form

Company Information

FBC Membership Number: ________________ FBC Rep. Name: __________________________ Number: _______

Business Name: ___________________________________ Type: ◯ Incorporated ◯ Sole Prop. / Partnership

Mailing Address: ____ Phone: ( ) _______________________

City: ____________________________________ Province: _________________ Postal Code: ______________

Company Administrator: _______________________________ Email: ___________________________________
(Person with administrator access to the HSA account) (Email becomes login username)

Health Spending Account (HSA) Setup

Select Benefit Year (Can be any 12-month period): ◯ Jan - Dec ◯ Other: _______________________

Establish Annual Limits (Single / Family):	**For Incorporated Company**	**For Sole Proprietor/Partnership**
Primary Employee* (Single / Family):	$ 10,000 / $ 10,000	$_________ / $_________
	Grey amounts are default. Any amount can be entered.	*$1500/adult and $750/child (max.) The total amount is the family amount.*

Once the HSA plan enrollment is complete, the Company Administrator can login and add secondary employees with different annual limits.

*A Primary Employee is defined as the person who provides overall direction and vision for the company.

Primary Employee and Dependant

Full Name: ______________________________________ Email: _________________________________
(Email becomes login username)

Date of Birth: (Y/M/D) _____________________________

Dependant - Name(s)	Relationship	Date of Birth (Y/M/D)	Post-Secondary Student*
________________________	*Spouse*	________________	Y / N
________________________	___________	________________	Y / N
________________________	___________	________________	Y / N
________________________	___________	________________	Y / N

* Students are eligible if they attend a post-secondary school full time and are 21-24 years old inclusive. Dependant / students who are 20 years old or younger are automatically eligible.

Version 0114

FBC InsurPak

(Optional for Incorporated companies, required for Sole Prop. and Partnerships. Coverage ends at 65 years of age.)

Choose coverage option:

○ Accept FBC InsurPak (Single: $29.99 / mo., Family: $39.99 / mo.) ○ Decline FBC InsurPak

FBC InsurPak coverage is effective the first day of the month following the receipt and approval of this enrollment.

Monthly Debit Authorization Form: I (we) authorize National HealthClaim and noted Financial Institution to withdraw funds from my (our) business account for the purpose of paying FBC InsurPak premiums. A debit in paper, electronic or other form may be drawn from my (our) account beginning the 15th day of the month after the enrollment has been signed. This agreement may be cancelled by either me (us) or National HealthClaim in writing, with at least 2 weeks (14 days) notice prior to the first day of the following month. I (we) also understand that should any withdrawal not clear my (our) account for reason of insufficient funds, National HealthClaim will automatically attempt to withdraw these funds within 10 days of the returned item without prior notification.

I (we) authorize National HealthClaim to process a monthly debit from my (our) account for the amount determined by the number of single and family employees on the system by the first day of each month.

Account Signature: ____________________ **Print Name:** ______________________ **Date:** _________

Please attach a VOID cheque to this application form to complete this authorization

Plan Authorization: By signing this enrollment form, the company agrees to provide a Health Spending Account for its employees and will pay for all account funding and administration fees as required. This forms a Contract of Insurance (copy available online for Company Administrator).

Company Signature: ___________________ **Print Name:** ______________________ **Date:** _________