



PRIVATE HEALTH SERVICES PLAN ENROLMENT

For Incorporated or Limited Companies

Date:

Advisor/Broker Name:

Company Legal Name:

Company Short Name:

Mailing Address:

Street Address:

City: Province: Postal code:

Daytime Phone: Fax: Email:

Contact Person:

of Employees:

Method of Payment (check one)

Cheque

Credit Card Credit Card #:

Expiry Date:

Name on Card:

I authorize CustomCare Inc. to debit my credit card for the amount of

Authorized Signature: _____

CustomCare Inc.

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admin@customcare.ca
www.customcare.ca