CustomCare™

Employee Enrollment Form

APPLICANT SECTION

COMPANY NAME			
EMPLOYEE'S NAME		DATE OF BIRTH DD / MM / YYYY	GENDER ☐ Male ☐ Female
ADDRESS		CITY	PROVINCE
POSTAL CODE	HOME PHONE ( )	EMAIL	

Employee Classification (please check one) ☐ Executive ☐ Management ☐ Full Time ☐ Support ☐ Part Time ☐ Other

Annual Benefit Limit $	Pro-Rate ☐ Yes ☐ No	Pro-Rated Amount $

☐ *I give CustomCare my express consent to contact me via email for questions on my account, product information and updates & reminders. I do understand that I can opt out of these emails at anytime.*

LIST OF DEPENDANTS

	NAME OF DEPENDANT(S)	RELATIONSHIP TO PLAN HOLDER	GENDER	DATE OF BIRTH
1.			☐ Male ☐ Female	DD / MM / YYYY
2.			☐ Male ☐ Female	DD / MM / YYYY
3.			☐ Male ☐ Female	DD / MM / YYYY
4.			☐ Male ☐ Female	DD / MM / YYYY

Dependants of an Eligible Employee are defined as:

1. A Spouse — who is either: a) legally married to the Employee; or b) a person who is living with the employee for 1 year or more and who is publicly represented as the Employee's spouse, significant other, life partner or mate.
2. Any member of the employees household with whom the employee is connected by blood relationship, marriage or adoption who is 21 years of age or younger, or is up to 25 years of age and attending post-secondary schooling full time.

BANKING DATA

Branch No. (5 figures)	Institution (3 figures)	Account No. (12 figures)
Name as shown on bank records		

I/we authorize the Company, and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions and/or direct deposits and/or refunds from time to time as per my/our instructions as set out herein, and/or payments as the case may be, for payment of all charges and/or refunds arising under my/our account(s) and arrangements and agreements with the Company. Refunds and/or payments for the full amount of services delivered will be credited/debited to my/our specified account as specified herein. This authority is to remain in effect until the Company has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days (but not longer than thirty (30) days) before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca. The Company may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us. I/we have certain recourse rights if any debit does not comply with this agreement. For example; I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.cdnpay.ca. Further by signing below, you represent and warrant as follows:

1) That you will not hold the Company responsible for any delay or loss of funds due to incorrect or incomplete information supplied by you or by your financial institution or due to an error on the part of your financial institution in depositing funds to your Account;
2) That you waive any pre-notification requirements as specified by sections 15 (a) and (b) of the Canadian Payments Associate Rule H1 with regards to recovering amounts directly from your Account in connection with amounts incorrectly credited to your Account.
3) That the Company may change its fees schedule by providing you with 30 days prior written notice of such changes. If you do not cancel this authorization during such notice period, this authorization shall continue to be used in conjunction with such revised fee schedule where applicable.
4) Where payments, funds transfer or refunds are in relation to personal services (other than business services) this authorization shall be considered a personal pre-authorized debit agreement.

Signature (as shown on bank records)	Other signature (joint account)

I wish to participate in the CustomCare Private Health Services Plan and confirm that the information above is correct.

EMPLOYEE'S SIGNATURE	DATE DD / MM / YYYY

I hereby confirm that the above mentioned Employee is eligible to participate in our CustomCare PHSP.

EMPLOYER'S SIGNATURE	ELIGIBLE DATE DD / MM / YYYY

PLEASE ATTACH A VOID CHEQUE WITH THIS APPLICATION

You have certain recourse right if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on your recourse rights, contact your financial institution or visit **www.cdnpay.ca** .

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