



Managing the health of your business is your responsibility;
Let the health of your employees be ours.

SINGLE FAMILY PLAN ENROLMENT FORM

Date: _____

(yyyy/mm/dd)

This form is for companies where the only employee of the company is the owner (often referred to as "owner-managed businesses"). This plan will cover the employee and their family (as described in the terms and conditions). The terms and conditions of this plan are a separate document that is updated from time to time as needed. Please see the HealthSmart website for these terms and conditions.

This plan requires that the Planholder have no more than one employee and is either a corporation or sole proprietorship. If your business does not meet this definition, please complete the application form for the Managed Plan instead.

Planholder Legal Name: _____

Contact Name: _____

This will be the only person authorized to make changes to this account
and will be referred to by HealthSmart as the Plan Administrator.

Corporate Mailing Address _____

Contact Phone Number _____

Contact Email Address _____

Planholder Fiscal Year End _____

Effective Date of the Plan (yyyy/mm/dd) _____

By signing below, I agree, on behalf of the Planholder, to the HealthSmart Single Family PHSP Terms and Conditions, which can be found on the HealthSmart website or by writing to HealthSmart at the address above. These terms and conditions may change from time to time. This form will not be processed if it is not signed or if it is incomplete or missing the enrolment fee.

Name of individual with the authority
to bind the Planholder: _____

Signature: _____

**Make sure to include a cheque made payable to HealthSmart PHSP Administration Ltd.
in the amount of \$100 (GST/HST Exempt) for the enrolment fee for this plan.**



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The following is a list of individuals that will be covered under this plan. The individuals that may be covered by this plan are:

- the Employee of the Planholder (if the Planholder is a corporation, the employee must receive a T4 from the Planholder)
- any member of the Employee's household related to the Employee by blood, marriage, or adoption.

Employee Name _____

Employee Date of Birth (yyyy/mm/dd) _____

Name	Date of Birth (yyyy/mm/dd)	Relationship to Employee (Circle One)
		Spouse By Blood By Adoption
		Spouse By Blood By Adoption
		Spouse By Blood By Adoption
		Spouse By Blood By Adoption
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		Spouse By Blood By Adoption

<p>For Office Use Only</p> <p>Date Received _____</p> <p>Account Opened Date _____</p> <p>Company # _____</p>
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