STRATEGIC
Benefits & Insurance Services Ltd.

myHSA Application

Company

Name: _____

Contact: _____ Direct Phone: _____

Administration Fee

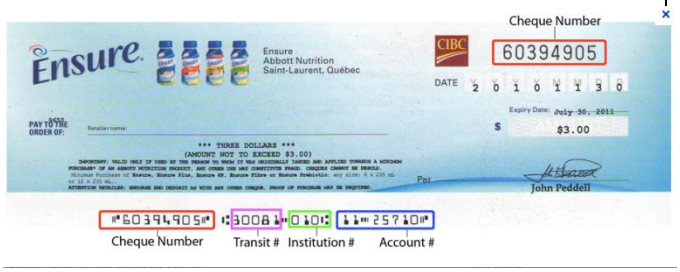
Total Administration Fee per claim: _____%

Corporate Banking Information

Please provide void cheque or fill in information below:
Bank Number (3 digits): _____

Transit Number (5 digits): _____

Account Number: _____



Company Administrator Contact Information

This person will receive an email with login information

Name _____

Login Email _____

Phone _____

Address _____

City _____

Plan Design Options

1. Classes of employee Employees must be classed by position and provided the same limit for each employee within that class. Any limits established over 15% of income should be reviewed by the company accountant

Plan 1 (Eg Executive Class): _____ Limit: _____

Plan 2 (Eg Management Class): _____ Limit: _____

Plan 3 (Eg Admin Class): _____ Limit: _____

Plan 4 (Eg Warehouse Class): _____ Limit: _____

Plan 5 (Other Class): _____ Limit: _____

Plan 6 (Other Class _____Limit: _____

2 - Percent paid of Covered claims: (□100% □ 80% □ 50% (Typical plan set up covers 100%)

3 - Expense List options: (Used to coordinate with an insured plan with reduced coverage in certain areas)

□ All HSA expense items claims. Default option as this is inclusive of all allowable expenses (Extended Health Care, Dental, and Vision expenses)

- □ Extended Health Care Coverage
- □ Dental Coverage
- □ Vision Coverage

5 - Pro-Rate type: □ Yearly (full amount available immediately) □ Semi Annually □ Quarterly □ Monthly

6 - Carry Forward (Unused benefits at the end of the benefit year): □ Forfeited □ Carried over to the next benefit year

7 - Start Date for Benefit Year (Renewal will be 1 year after): _____

8- Travel & Catastrophic Coverage $8.75 per month per employee (Plus Admin Fees/Year for single, couple, family)
□ Yes □ No

ACKNOWLEDGEMENT AND CONSENT

I certify that all the information is true and complete and agree to the Acknowledgement and Consent in this application.

Signature of Plan

Contract Holder (required):_____ Date: _____

(MM/DD/YYYY)

This consent is obtained in accordance with The Ontario Health Care Consent Act, and the federal Personal Information Protection and Electronic Documents Act.

I certify that the information contained on this application is true and complete. I understand that the personal information provided herein, may be used or disclosed only to determine eligibility for benefits, verify, assess and pay claims, administer the terms of my benefit plan and policy and to manage the Company's business. I certify that I am authorized by my spouse and/or other adult dependants to disclose and receive information about them that is used solely for these purposes.

I hereby acknowledge and agree that my / my dependant's personal information may be exchanged between 1181529 Ontario Ltd. and a licensed physician and / or other health care professional, institution or health benefits provider or insurer or government or regulatory authority and only as needed for the purpose stated above.

I understand that my / my dependant's personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, the coverage may be denied or rescinded. I understand why my / my dependant's personal information is needed and am aware of the risk and benefits of consenting or refusing consent to its use as described above.

I have read and understood this Acknowledgment and Consent and authorize 1881529 Ontario Ltd. to collect, use and disclose my / my dependant's personal information as described above. This consent shall be effective from the earlier of the date of signature of this form, or the effective date of this plan and shall remain in effect as long as the coverage is in force.