STRATEGIC Benefits & Insurance Services Ltd.

myHSA Employee Enrollment

Please complete a separate form for each employee

Company:_____

Class: _____ Effective date: _____

Employee: _____

Home Address:_____

City:_____ Province _____ Postal Code: _____

Home Phone:_____ Office Phone:_____

Personal Email: _____

Birthdate:_____

Coverage: ☐ Single ☐ Family

Dependents First Name	Last Name	Sex	**Birthdate** Day	Month	Year

Spouse

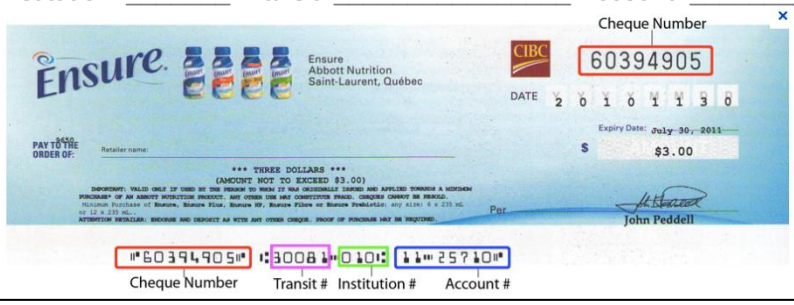
Dependent children may be natural, adopted or step-children. Must be unmarried and dependent on you for support. Under 21, or under 25 and attending post-secondary education, or dependent due to mental or physical infirmity.

Authorized Direct Deposit of Claim

Please attach a VOID personal cheque (**only** if not available, complete below)

Bank Name: _____

Institution: _____ Transit: _____ Account: _____



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 Employee (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.