HEALTH SPENDING ACCOUNT ENROLMENT FORM

MDM INSURANCE SERVICES INC.

Privacy Statement MDM Insurance Services Inc. is committed to protecting the privacy, confidentiality, accuracy, and security of the personal information that it collects, uses, retains, and discloses in the course of conducting business. We will not disclose your information to a 3rd party without your personal and prior approval. A. PERSONAL INFORMATION Last name: First name: Initial: Home mailing address: Street Postal Code /MM /DD Date of birth: YY ☐ Male ☐ Female ☐ Single ☐ Married ☐ Common-law* ☐ Other_ Language preference: ☐ English ☐ French e-mail address: Banking information: transit # account # B. DEPENDENT ENROLMENT *** All dependents listed must be eligible as defined by the Income Tax Act. *** Initial Date of Birth Dependent Last Name First Name Gender (yy/mm/dd) Spouse \square M ΠF Child \square M □F Child \square M □F Child \square M □F Other Complete and attach a Health Spending Account Dependent Declaration for non-standard dependents. C. CO-ORDINATION OF BENEFITS **Extended Health Care** Are you or your dependents currently covered under another group medical insurance policy? ☐ Yes ☐ No **Dental Care** Are you or your dependents currently covered under another group dental insurance policy? ☐ Yes ☐ No D. EMPLOYEE SIGNATURE AND AUTHORIZATION I certify that the information contained herein is true, complete and accurate and that each of the listed expenses was purchased and/or incurred in connection with medical treatment of the above-named individual(s). I acknowledge that the submission of false or incomplete information may result in the delay or denial of this claim. I authorize any physician, dentist or any health care provider and/or facility, any insurance company, benefit service provider and any other person or organization having any medical or other relevant personal information regarding me or my spouse and/or dependent(s) to release to and exchange with MDM, the group plan administrator or their representatives and/or agents any and all information necessary to investigate and confirm the accuracy and validity of this claim, determine eligibility for benefits and/or administer the claim and group benefit plan. I confirm that I am authorized to act on behalf of my spouse and/or dependent(s) for such purposes. Any copy of this authorization shall be as valid as the original. Signature: _____ Date: _____ E. EMPLOYMENT INFORMATION - to be completed by employer Group #: Employer Name: Part-time employment commenced (Y/M/D): Full-time employment commenced (Y/M/D): HSA Option # _____ Employer Signature: ______ Date: _____ Title:

ENROLMENT FORM INSTRUCTIONS

Please clearly print all information in ink.

SECTION A - PERSONAL INFORMATION (to be completed by the employee)

- 1. Clearly print your name and full mailing address including postal code.
- 2. Enter date of birth in year, month, day format and mark an "x" to indicate gender and family status.
- 3. Enter your e-mail address and banking information to have your claims processed electronically. Your bank account will be automatically credited in the amount of your claim. An Explanation of Benefits will be sent to you via e-mail.

SECTION B - DEPENDENT ENROLMENT (to be completed by the employee)

- 1. Print last and first name of each person eligible to be covered under your employer's benefit plan. Attach separate sheet if additional space is required.
- 2. Enter the full birth date in year, month, day format for each dependent. Please ensure the accuracy of birth dates as it will affect claims payment and dependent eligibility.
- 3. Indicate gender of dependent.

SECTION C - CO-ORDINATION OF BENEFITS (to be completed by the employee)

For Extended Health Care and Dental Care, indicate if coverage for you or your dependents is also available from another source

SECTION D - EMPLOYEE SIGNATURE AND AUTHORIZATION (to be completed by the employee)

This form must be signed and dated by the employee.

SECTION E - EMPLOYMENT INFORMATION (to be completed by the employer)

- 1. Enter your company name (Employer Name) and Group Number if not already pre-filled (please print).
- 2. Enter the actual date that full-time employment and/or part-time employment commenced.
- 3. Enter the HSA Option Number applicable to the employee.
- 4. Sign and date to authorize the enrollment of the employee.

TO AVOID DELAYS, PLEASE ENSURE ALL REQUIRED INFORMATION IS PROVIDED.

SEND COMPLETED ENROLMENT FORM TO:

MDM Insurance Services Inc. P.O. Box 970 Guelph, Ontario N1H 6N1