HealthCare Spending Account
Enrollment Form

corporateHCSA
by National HealthClaim

Policy # ______________________
(NHC Use)

A Company Information

Legal Name of Company: ______________________ Phone: (   ) ______________

Address: ______________________ City: ______________

Province: ______________________ Postal Code: ______________

Company Plan Administrator: ______________________ Email: ______________

Broker Name: ______________________ Broker Email: ______________

B Health Spending Account - Plan Details (See section E for additional information)

1. Choose job classification(s) for the employees of your company. It is required that each employee within a classification be extended the same annual limits.
2. Please make sure the descriptions are accurate. Examples are shown below.
3. Enter the annual limit amounts. The grey amounts are default - any amount can be entered.

	JOB CLASSIFICATION	JOB DESCRIPTION	ANNUAL LIMIT SINGLE	ANNUAL LIMIT FAMILY	WAITING PERIOD	PRO-RATED
A	Executive	Has the authority to enter into contracts on behalf of the company and is responsible for the overall direction and vision.	$5,000	$10,000	30 d	Y / N
B	Manager	Is responsible for all hiring and supervision of employees within their areas of responsibility.	$1,000	$2,000	30 d	Y / N
C	Full Time Employee	Performs daily operational duties and works for at least 30 hours a week.	$750	$1,500	30 d	Y / N
D	Administration Only	This category is for individuals who are only administrating the plan and will not have an HSA amount assigned to them.	N/A	N/A	N/A	N/A
E	Other					

Plan Effective Date: ______ / ______ / ______
(YYYY / MM/ DD)

When the plan is to start. The plan can be back-dated up to one year (will apply to all employees)

Benefit Year:
- ☐ January to December
- ☐ Other: ______________

The 12 month cycle that claims are made against. You can align it to your fiscal year or keep it to a calendar year.

Carry Forward:
(Choose one option)
- ☐ Use Credit Carry Forward
- ☐ Use Expense Carry Forward
- ☐ **DO NOT** use Carry Forward

Credit Carry: Unused credits from one benefit year can transfer to the next year after the runoff period has ended.
Expense Carry: Expenses (receipts) from one benefit year can be claimed in the next year, after the runoff period has ended.
No Carry: Credits must be used within each benefit year only.

Run-off: [30 / 60 / 90] Days

Number of days from start of new benefit year during which claims can be made against the previous year. Typical is 60 days to allow adequate time.

Student Dependent Cut-Off Age: [24]

Child Dependent Cut-Off Age: [20]

Child dependents attending full-time post secondary school remain eligible until, and including, this age.
Child dependents remain eligible until, and including, this age.

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C Enter Your Employee & Dependent Information (Attach additional pages for more employees - there is no limit)

EMPLOYEE INFORMATION

Full Name: ______________________

Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D ☐ E
(From Section B)

Date of Birth: ______________________
(YYYY / MM / DD)

Date of Hire: ______________________
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
	Spouse		
	Child		Y / N
	Child		Y / N
	Child		Y / N

EMPLOYEE INFORMATION

Full Name: ______________________

Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D ☐ E
(From Section B)

Date of Birth: ______________________
(YYYY / MM / DD)

Date of Hire: ______________________
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
	Spouse		
	Child		Y / N
	Child		Y / N
	Child		Y / N

EMPLOYEE INFORMATION

Full Name: ______________________

Email: ______________________
(This will be used as the website username)

Job Classification: ☐ A ☐ B ☐ C ☐ D ☐ E
(From Section B)

Date of Birth: ______________________
(YYYY / MM / DD)

Date of Hire: ______________________
(YYYY / MM / DD)

Dependents

Name	Relationship	Date of Birth (YYYY / MM / DD)	Student
	Spouse		
	Child		Y / N
	Child		Y / N
	Child		Y / N

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D Authorization

By signing this enrollment form, the company agrees to provide a HealthCare Spending Account for its employees and will pay for all account funding and administration fees as required.

Signature of Authorized Company Officer: ______________________ Date: ______________ (YYYY / MM / DD)

Print Name: ______________________

- ☐ Pre-Funding Cheque Attached (optional)
- ☐ Sign and return Indemnity Contract

If your company has less than 1-8 employees, there is an enrollment fee of $300 + GST.

National HealthClaim Corp.
335 58th Ave S.E.
Calgary, Alberta,
T2H 0P3

E Additional Information

HealthCare Spending Account Funding

A company can choose to provide funding for their HCSA by either “Pay-as-you-go” (generate a cheque for each expense claim submitted) or by “Pre-funding”. To utilize the “Pre-funding” method, a company is required to send in a block of money that will be held in an account and drawn from as HCSA claims come in. By “Pre-funding” an account, claims will be processed immediately. All HCSA accounts will operate in either mode, automatically. NHC does not pay interest on monies held.

Other Plan Options

The Corporate HCSA program can accommodate a variety of advanced plan features. For example, Credit Carry Forward allows unused limits from one year to move to the next year and by using Pro-rating and/or Waiting Period options, new employees are only extended their HCSA limit when they have completed their start-up requirements.

Privacy Statement

Protecting the insured person’s personal information at National HealthClaim Corp. (NHC) is very important. We recognize and respect the company and individual’s privacy. When a company enrolls for an HCSA, we establish a confidential file that contains their account and employee information. This file is kept in the offices of NHC. We collect and use the personal information to process this enrollment and provide and administer the financial product(s) enrolled for, investigate and process claims, and create and maintain records concerning our relationship.

What Happens Next?

1. The signed enrollment form is sent to National HealthClaim for review and entry into their administration system. NHC may contact the company Plan Administrator or Broker to discuss the enrollment if there are questions. It is important that the Plan Administrator indicate their email address on the enrollment form.

2. An email will be sent to the company “Plan Administrator” with instructions for logging onto the Corporate HCSA web site. Changes to the Plan or Employees can be done directly by the Plan Administrator through the web site.

3. An email will be sent to each employee with instructions for logging onto the Corporate HCSA web site. Claims are made directly on the web site. The employee username for the login is the email address submitted on the enrollment form and must be unique to each employee.

Web: www.corporateHCSA.com

Toll Free: 866 342-5908

NATIONAL HEALTHCLAIM CORPORATION