



APPLICATION SCHEDULE

Section A - Employer Profile

Employer's Legal Name

Employer's Address

City

Province

Postal Code

Employer's Phone Number

Employer's Fax Number

Revenue Canada Employer No.
(if available)

Type of Business (check one): corporation

proprietorship

professional corporation

partnership

Fiscal Year End

Section B - Plan Options

Effective Date of Plan

Plan Year End

Plan Coverage Options (check one or more):

All eligible medical expenditures as defined by the Income Tax Act.

Dental Services Only Vision Care Only

Dental Service and Vision Care Only

Unused Portion of Employees' benefits at Plan Year End (check one):

Forfeit the benefit

Roll the benefit over into the next Plan Year
(maximum one year rollover based on LIFO)

Is the Plan Optional to Employees?:

Yes No

If yes, may the Employee Opt in at any time?:

Yes No

Eligibility of New Employee (check one):

- Immediately upon Date of Hire
- Other (Provide Particulars)

Termination of Departing Employee (check one):

- Immediately upon Date of Termination
- Other (Provide Particulars)

Particulars:	Particulars:
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Section C - Maximum Annual Benefit

Maximum Annual Benefit Level for Each Classification of Employee:

EMPLOYEE CLASSIFICATION	EMPLOYEE	DEPENDENTS (if covered)
1. Executives	\$ _____	\$ _____
2. Senior Management	\$ _____	\$ _____
3. Full-time employees	\$ _____	\$ _____
4. Part-time employees	\$ _____	\$ _____
5. Commissioned staff	\$ _____	\$ _____
6. Other	\$ _____	\$ _____
7. Other	\$ _____	\$ _____
8. Other	\$ _____	\$ _____

Section D - Employee Profile

Include the following information for **EACH** eligible employee (attach to plan):

- Name
- Classification of Employee (see above)
- Full address (only if outside of Alberta)
- Number of Dependents (if covered)

I hereby certify I wish to participate in the Employee Private Health Services Plan and that the information above is correct to the best of my knowledge.	Date:	Signature of Employer:
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Agent: _____