Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Employer/Owner Information
Cost Plus Plan

Send to:
Email: luene@healthrisk.ca
Fax: (403) 236-9420
Mail: 50, 12221 - 44th Street SE
Calgary AB T2Z 4H3

COMPANY INFORMATION

Legal Company Name:		**Operating As:**	
Owner's Last Name:	**First Name:**	**Middle Name:**	
Company Address:		**Website:**	
City:	**Province:**	**Postal Code:**	**Email:**
Business Phone:	**Cell Phone:**	**Home Phone:**	**Fax:**
Nature of Business:			
BIN#	**Date of Incorporation: (mm/dd/yyyy)**	**Business/Corporate Fiscal Year End: (mm/dd/yyyy)**	
No. of Years In Business:		**No. of Years Self-Employed:**	
No. of Employees:	**Total Full Time:**	**Total Part Time:**	**Commissioned Sales:**	**All Other Employees:**
No. of Owners:	**No. of Executives:**	**No. of Management:**	**No. of Contractors:**

BENEFITS / INSURANCE INFORMATION

Does your business currently own or have a Benefits/Insurance Plan in place? ☐ Yes ☐ No

If "No" please move to the "Benefits/Insurance Plan Inquiries" section on page 2 of this form.

If "Yes" please complete the following section in as much detail as possible.

What type of Plan do you currently have in place?

Current Benefits/Insurance Provider:	**Policy Number:**
Will this new plan replace your current plan? ☐ Yes ☐ No	**If "NO", do you wish to coordinate Benefits?** ☐ Yes ☐ No

Do you currently have any of the following types of Insurance Plans in place either for Business or Personal use?

- ☐ Life
- ☐ Accidental Death & Dismemberment
- ☐ Dependent Life
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Critical Illness
- ☐ Business Insurance
- ☐ Mortgage Insurance
- ☐ Emergency Travel
- ☐ RRSPs
- ☐ TFSAs (Tax Free Savings Account)

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BENEFITS / INSURANCE PLAN INQUIRIES

Health Risk Services Inc. offers brokerage, third party administration and program design & education services for products in the following categories. Please forward your inquiries if you wish to add, upgrade, make adjustments to or develop a new program for business or personal use. Please check all that apply.

- ☐ Life Insurance
- ☐ Accidental Death & Dismemberment
- ☐ Dependent Life Insurance
- ☐ Short-Term Disability
- ☐ Long-Term Disability
- ☐ Critical Illness
- ☐ Business Insurance
- ☐ Mortgage Insurance
- ☐ Emergency Travel
- ☐ RRSPs
- ☐ TFSAs (Tax Free Savings Account)
- ☐ World Care 2nd Opinion
- ☐ Business Assistance Plan
- ☐ Employee Assistance Plan

Additional Comments or Inquiries:

AUTHORIZATION AND SIGNATURE

I consent to the collection, use and disclosure of my personal information for the purposes of communication, underwriting risks, investigation and adjudication of claims, detection and prevention of fraud, compiling of statistics and acting as required and authorized by law. I also authorize my plan sponsor to this same information for benefits administration and to make any necessary payroll deductions which may be required. I certify that all information in this form is true and accurate.

I acknowledge that Health Risk Services Inc. will continue to educate me regarding my benefits program and additional products and services available to myself and my family through Health Risk Services Inc. I am aware that this information may be forwarded through my employer or to my personal residence.

Authorized Employer/Owner Signature:	**Employer/Owner Name: (Please Print)**	**Date Signed: (mm/dd/yyyy)**