EMPLOYER / OWNER INFORMATION

Cost Plus Plan

1 COMPANY INFORMATION

LEGAL COMPANY NAME

OPERATING AS

OWNER 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)

FISCAL YEAR END (MM/DD/YYYY)

YEARS IN BUSINESS

YEARS SELF-EMPLOYED

NO. OF EMPLOYEES

FULL-TIME

PART-TIME

COMMISSIONED SALES

OTHER EMPLOYEES

OWNERS

EXECUTIVES

MANAGEMENT

CONTRACTORS

2 INCOME INFORMATION

PERSONAL ANNUAL TAXABLE EARNED INCOME

Cost Plus Account designation (select one):

☐ 10% ☐ 15%

PRE-AUTHORIZED DEBIT (PAD)

Automatic Debit Verification

☐ I have completed and submitted my Pre-Authorized Debit (PAD) agreement and included a void cheque.

Health Risk Services Inc.

EMPLOYER / OWNER INFORMATION
Cost Plus Plan

3 BENEFIT INFORMATION

Do you currently have a benefit plan in place? ☐ Yes ☐ No

If yes, please complete the following:

TYPE OF CURRENT PLAN

CURRENT BENEFITS PROVIDER

Will this replace your current plan? ☐ Yes ☐ No

If no, do you wish to coordinate benefits? ☐ Yes ☐ No

4 BENEFITS / INSURANCE PLAN INQUIRIES

Health Risk Services Inc. offers brokerage, third party administration, program design and education services. Please select any products or services you would like to inquire about.

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

5 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 certify that all information in this form is true and accurate to the best of my knowledge.

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.

OWNER SIGNATURE (TYPE NAME OR SIGN IN ADOBE)

OWNER NAME (PLEASE PRINT)

DATE SIGNED (MM/DD/YYYY)