Health Risk Services Inc.

Providing Your Innovative Benefits Solutions

Owner Information Form For Contractor Wellness Allowance Policy

COMPANY INFORMATION

Company Name or Operating as:			
Owner's Last Name:	First Name:	Middle Name:	
Company Address:	Website:		
City:	Province:	Postal Code:	Email:
Business Phone Number:	Cell Number:	Home Number:	Fax Number:
Nature of Business	BIN#		
Date of Incorporation: (dd/mm/yyyy)	Year End Date: (dd/mm/yyy)	No. of Years in Business:	No. of Years Self Employed:

PLAN & SETUP

Contractor Wellness Allowance Policy

PLAN SET

☐ **Calendar Year** ☐ **Policy Year**

FREQUENCY OF FUNDING:

Annual ☐ **Semi-Annual** ☐ **Quarterly** ☐ **Monthly** ☐

CONTRACTOR DETAILS

Company Name or Operating as:	Last Name, First Name of contracted individual:

CONTRACTOR BENEFITS & RESTRICTIONS

Contractor Benefits Offering (Check all that apply)

☐ Health ☐ Wellness ☐ Retirement

☐ Insurance ☐ Travel ☐ Investments

Restrictions Section (List anything you would like to restrict)

#50, 12221 - 44 Street SE Calgary AB T2Z 4H3 | 403.236.9430 | 1.877.236.9430 www.HealthRisk.ca | info@healthrisk.ca

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

PRE-AUTHORIZED DEBIT (PAD)

Automatic Debit Verification

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

AUTHORIZATION AND SIGNATURE

I certify that the information provided on this form is true, complete, and accurate to the best of my knowledge. I understand that this information will be used for the administration of the Contractor Wellness Allowance Policy. I authorize the company to collect, use and maintain this information for the purpose of determining the eligibility, processing reimbursements, and administering the wellness allowance program in accordance with applicable policies and privacy requirements. I acknowledge that I have read, understood and agree to comply with the terms and conditions of the Contractor Wellness Allowance Policy.

I acknowledge that Health Risk Services Inc. may provide ongoing education, guidance and information regarding the Contractor Wellness Allowance Policy, eligible wellness expenses, program enhancements, and other health, wellness and benefit related products and services that may be relevant to my participation in the program.

I understand and acknowledge that information related to the Contractor Wellness Allowance Policy may be communicated to me through my company and/or mailed or otherwise delivered to my personal residence

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

FORM SUBMISSION

Once completed the Owner Information Form for Contractor Wellness Allowance policy should be sent to:

Health Risk Services Inc.
#50, 12221 - 44th St SE
Fax: (403) 236-9420
email: info@healthrisk.ca

Go to HealthRisk.ca to learn more about our other products and services

Ask us about our referral program!