



Employee Enrolment Form

EMPLOYEE INFORMATION

Name: _____

Address: _____ Apartment #: _____

City: _____ Province: _____ Postal Code: _____

Phone number: _____ E-mail address: _____

Gender: Male Female Single Family Date of Birth (m/d/yr): _____

DEPENDENT INFORMATION

Name	Birth Date (m/d/yr)	Gender M or F	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FINANCIAL INFORMATION

I authorize the Wellkmit Services Inc. to deposit my claims payments directly to my bank account as described in the attached voided cheque. I reserve the right to change accounts subject to giving Wellkmit 30 days to make such changes. Wellkmit reserves the right to reverse any deposits made in error to your account.

I certify that the information is complete and accurate. I authorize Wellkmit Services Inc. to proceed and implement the Plan and to collect and use personal information about me and/or my eligible dependents to process the claims and administer my Plan. I authorize Wellkmit to deduct the appropriate claims processing fees from my Plan.

I understand that my Plan Benefits are earned monthly but payments could be made based on my annual maximum benefit. Should I make claims on my Account and leave my employer before the end of the Plan Year, the Company has the right to recover any payments made that exceeded what I had earned.

Employee Signature _____ Date _____

Please remember to attach your void cheque

<p>For Office Use</p> <p>CORPORATE INFORMATION</p> <p>Company Name: _____</p> <p>Annual Maximum Benefit: \$ _____ Effective Date of coverage: M: _____ D: _____ YR: _____</p> <p>Authorized Signature: _____</p>
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