



Health Spending Account

Schedule A - AB, MB, SK, Territories

1. COMPANY INFO	Incorporated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Employees:	Plan Start Date: YYYY MM DD	
	Company Name:			
	Street Address:		Unit #:	PO Box:
	City:		Province:	Postal Code:
	Telephone:	Fax:		
	Owner:	Email:		
	Plan Administrator:	Email:		

2. CONTRIBUTION PERIOD & SCHEDULE	Contribution Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually				
	Employee Name	HSA	HSA Complete	Travel Assist	
	1.				
	2.				
	3.				
	4.				
	5.				
	6.				
	7.				
	8.				
Subtotal		\$ A	\$ E	\$ F	

3. PAYMENT & INITIAL DEPOSIT INFO	Payment & Deposit	
	A - Subtotal (from A above)	\$
	B - Administration Fee (A x .10)	\$
	C - GST & Premium Tax on Admin Fee [B x (.05 + .02)]	\$
	D - Premium Tax on Subtotal (A x .02)	\$
	E - Subtotal (from E above)	\$
	F - Subtotal (from F above)	\$
	Payment Total (A + B + C + D + E + F)	\$
Initial Deposit	\$	

4. PAYMENT OPTIONS	Pre-Authorized Payment: The Pre-Authorized Payment (PAP) option is not available if you choose an Annual contribution period. Please complete the Pre-Authorized Payment Plan Agreement on page 2 and submit a void cheque with the agreement. Pre-authorized Payments will begin on the 25th day of the month prior to the second contribution period. Please include a deposit cheque to cover the first contribution period. Make the deposit cheque payable to BENCAID-IN-TRUST.
	Cheque: Please include a deposit cheque to cover the first contribution period. Cheques for subsequent contribution periods must be received by Benecaid by the first day of the month of each contribution period. You may choose to submit post-dated cheques. Make the deposit cheque and all subsequent cheques payable to BENCAID-IN-TRUST.

Make Deposit Cheque Payable to BENCAID-IN-TRUST

Signature of Signing Authority:	Date Signed: YYYY MM DD
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The information above, including any supporting information presented by Benecaid, is not intended for consulting purposes and shall not be interpreted in any jurisdiction as constituting a recommendation, advice, opinion or endorsement concerning the implementation or change or strategic action, underlying benefit plans or any other financial instrument or as constituting legal, accounting, tax, human resource, labor, financial, investment or other advice. Past performance of benefit plans is not necessarily indicative of future performance. Therefore, Benecaid recommends that you consult your own professional advisors in accordance with your needs.



Schedule A HSA Pre-Authorized Payment (PAP) Plan Agreement

Please read and complete the Pre-Authorized Payment Plan Agreement below.

I/We authorize Benecaid Health Benefit Solutions Inc., and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions as per my/our instructions for regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Benecaid Health Spending Account. Regular payments for the full amount of services delivered will be deducted from my/our specified account on the 25th day of the month per my/our Health Spending Account contribution schedule. Benecaid Health Benefit Solutions Inc. will provide five (5) days written notice of the amount of regular debit. Benecaid Health Benefit Solutions Inc. will obtain my/our authorization for any other one-time or sporadic debits.

This authority is to remain in effect until Benecaid Health Benefit Solutions Inc. has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAP Agreement at my/our financial institution by visiting www.cdnpay.ca.

Benecaid Health Benefits Solutions Inc. may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least ten (10) days prior written notice to me/us.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAP that is not authorized or is not consistent with this PAP agreement. To obtain a form for reimbursement claims, or for more information on my/our rights, I/we may contact my/our financial institution or visit www.cdnpay.ca.

Date: YYYY MM DD		PAP Category: BUSINESS	
Company Name:			
Street Address:		Unit #:	PO Box:
City:		Province:	Postal Code:
Telephone:			
Name of Designated Financial Institution:			
FI Code: (3 digits)	Transit: (5 digits)	Account:	
Name of Signing Officer:			
Authorized Signature:			
Name of Signing Officer:			
Authorized Signature:			
PLEASE ATTACH A VOID CHEQUE			

Benecaid Health Benefits Solutions Inc.
Attn: Data Management Department
PO Box 40
Toronto, ON M9C 4V2