



Catastrophic (Stop Loss) / Travel Medical Plan

Employee Enrolment Form

Company Name: _____

Employee Name: _____ Gender: M / F

Date of Birth: _____ * Maximum Coverage is age 70

Employee Address: _____

City: _____ Province: _____ Postal Code: _____

Coverage applying for:

- Single [Annually \$91.44 or Monthly (PAD only) \$8.00]
- Couple [Annual \$174.84 or Monthly (PAD only) \$15.38]
- Family [Annual \$223.40 or Monthly (PAD only) \$19.68]

Effective Date of Coverage: 1st Day of _____, 20_____

Dependant(s) to be covered:

Name	M / F	Relationship	Birthday (dd/mm/yy)

Total Premium for this employee (paid by Company)

- Annually Cheque attached \$ _____ cheque #: _____
- Monthly 1st Months premium attached \$ _____

If this is the first employee enrolled into the plan, please submit PAD Form and VOID Cheque

Employee signature: _____ Date: _____

Company signature: _____
Employer or Administrator

Please return this form to:
 Health & Welfare Trust (Flexsave) Division - HUB Financial Inc.
 1001, 3700 Steeles Avenue West
 Woodbridge, ON L4L 8M9
 Phone: 1 (800) 561-2405 (option 2) or Fax 1 (866) 417-8394
www.hubfinancial.com