

Employer Application

FlexSave™

Client Account Information

Legal Business Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Key Contact

Name: _____ Email: _____

Plan Information

Effective Date: _____ Benefit Year: _____
DD/MM/YYYY MM/YYYY - MM/YYYY

Unused benefit to be: Forfeited Carry Forward Maximum Carry Forward Receipts
(Only ONE can be selected)

Plan Design

Employee Classification		Maximum Fixed Annual Benefit Amount		
Class Code	Class Level (ex: owner, executive, admin, laborer)	Health/Dental	Wellness	% Co-Pay*
A				
B				
C				
D				
E				

*Co-Pay percentage will default to 100% employer paid if not otherwise specified

\$250.00 Non-refundable setup fee included: Cheque Credit Card

Authorized Person: _____ Authorized Signature: **X** _____

Advisor Name: _____ Advisor Signature: **X** _____

Advisor Email: _____ *Advisor will be included in email confirmation of plan registration.

