Employer Application

FlexSave™

Client Account Information

Legal Business Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Key Contact

Name: _____ Email: _____

Plan Information

Effective Date: _____ (DD/MM/YYYY)

Benefit Year: _____ (MM/YYYY - MM/YYYY)

Unused benefit to be: *(Only ONE can be selected)*

☐ Forfeited ☐ Carry Forward Maximum ☐ Carry Forward Receipts

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.*

HUB

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