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IMAX SOLUTIONS

Employee Enrollment Form

Plan Sponsor Name: _____ **Contract# (if known)** _____

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Employee First Name		Last Name		Middle Name	Date of Birth
Mailing Address				Marital Status	mm-dd-yy
City		Province		Postal Code	Gender
Phone		Cell		Email	

First Name of Dependent(s)	Last Name	Middle Name	Relationship	Date of Birth	Gender
1.				mm-dd-yy	
2.				mm-dd-yy	
3.				mm-dd-yy	
4.				mm-dd-yy	

COMPLETE IF CHILD(REN) OVER AGE 21

_____ is a full-time student attending a post-secondary Educational Facility
(Dependent Name)

_____ is a full-time student attending a post-secondary Educational Facility
(Dependent Name)

COMPLETE IF DEPENDENT IS PARENT OR DISABLED ADULT CHILD

Do you currently claim your parent(s) or disabled adult child as dependent(s) on your income tax return? ☐ Yes ☐ No
If yes, you may add your parent(s) or disabled adult child as dependent.

PERSONAL BANK INFORMATION TO RECEIVE YOUR CLAIM PAYMENT VIA DIRECT DEPOSIT

Transit # (5 digits) Bank # (3 digits) Account #

READ AND SIGN BELOW

This program may involve elements of employee confidentiality. I have been informed and am aware of the implications of the freedom of information and privacy protection act.
I understand, this program does not provide travel insurance. It is advisable and recommended that travel insurance be purchased any time out of country travel is contemplated. I wish to participate in the Employee Health Care Plan and declare the information above is correct.

Employee Signature: X _____

THIS SECTION TO BE COMPLETED BY PLAN SPONSOR

Code Classification	Payroll / ID Number	Annual Limit With Dependents	Annual Limit Without Dependents

Codes: **1**. Owner **2**. Senior Management **3**. Full-time Employee **4**. Part-time Employee **5**. Hourly **6**. Other (specify)

I, an authorized representative of the plan sponsor, hereby confirm that the above named employee is eligible under the terms of the employee health care plan and that the employee is entitled to be reimbursed for eligible medical expenses as herein described. The undersigned agrees to notify Imax of any changes to the plan initiated by the plan sponsor.

For the above employee the **EFFECTIVE DATE** of the plan is: _____

Plan Sponsor Signature: X_____ Date _____