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Private Health Services Plan - Plan Design

Broker Name: _____

1) PLAN SPONSOR INFORMATION

Legal Company Name		
Address		
City	Province	Postal Code
Telephone	Fax	Email
Contact Name	Fiscal Year End 00 (mm) 00 (dd)	

Check one: ☒ Corporation ☐ Sole Proprietor

BENEFIT INFORMATION

Number of days after Plan Year to file claims for Forfeit Plans (between 0 and 365 days)

☐ Number of days _____

Last years claims will reduce new years plan amount.

Allowable Expenditure options

☐ Dental Basic ____ % ☐ Major ____ % ☐ Ortho ____ %

☐ Prescription Drugs ____ % ☐ Extended Health ____ %

☐ Out of Province ____ % ☐ Vision expenditures ____ %

Assignment to Dental Providers "Funds On Deposit Accounts Only" ☐ Yes ☐ No

Coverage Effective Date 00 (mm) 00 (dd) 0000 (yyyy) Eligibility effective date for all employees will commence on this date unless otherwise noted on **Employee Enrollment** form.

Unused benefits at fiscal year end will: ☒ Rollover ☐ Forfeit | Funds on Deposit Accounts Allow Copies of Receipts ☐ Y ☐ N

Specify the annual fixed maximum reimbursement limit you want for each classification of employee participating in the plan. If you want different reimbursement limits for employees without dependents, please indicate the amount in the appropriate column.

EMPLOYEE CLASSIFICATION		FIXED ANNUAL REIMBURSEMENT LIMIT	
CODE	DESCRIPTION	WITH DEPENDENTS	WITHOUT DEPENDENTS
1	Owner		
2	Senior Management		
3	Full Time		
4	Part Time		
5	Hourly		
6	Other		

3) FUNDING OPTIONS

OPTION	AMOUNT	DESCRIPTION
☐ Monthly Invoice		Monthly invoice mailed for specified amount
☐ With Claim (Pay as you go)		Each claim is submitted with the required funds for that claim
☐ Lump Sum (Initial)		Claims pool to be repleneshed as needed

4) EMPLOYEE INFORMATION

When does the employee become terminated from the plan? _____ days after employment termination	Are Employees allowed to opt out of plan? ☒ Yes ☐ No Are Employees allowed to opt back in? ☒ Yes ☐ No (Attach employee enrollment or opt out forms for the total number of eligible employees) **Note: Plan Sponsor is responsible for notifying Imax Financial Services Ltd. when there are any changes to the plan.**
Future Employees are eligible _____ days / months following hire date	Number of Eligible Employees: _____

Please list ALL participating employees (Attach another page if necessary).

Code (from above	**First Name**	**Initial(s)**	**Last Name**