



Appendix A: Eligible Claimant Information

This form constitutes an amendment as Appendix A to the PHSP agreement. Use this form to make any changes to the list of Covered Employees as eligible claimants for your PHSP.

Aquilian Benefits Planholder Name: _____

Employee Name: _____ Add/Update Delete

Postal Address: _____

Email Address: _____

Eligible Date: _____ Class: _____
dd/mm/yy A/B/C/D/E

Employee Name: _____ Add/Update Delete

Postal Address: _____

Email Address: _____

Eligible Date: _____ Class: _____
dd/mm/yy A/B/C/D/E

Employee Name: _____ Add/Update Delete

Postal Address: _____

Email Address: _____

Eligible Date: _____ Class: _____
dd/mm/yy A/B/C/D/E

Employee Name: _____ Add/Update Delete

Postal Address: _____

Email Address: _____

Eligible Date: _____ Class: _____
dd/mm/yy A/B/C/D/E

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