Private Health Services Plan (PHSP) Enrolment Form

Part A: Identification

Planholder Legal Name: _____
Can be corporate name, partnership or sole proprietorship

Is Planholder Incorporated: Yes: ☐ No: ☐

Contact Person: _____

Mailing Address: _____

_____

_____

Contact Phone Number: _____ Fiscal Year End: _____

Contact Email Address: _____

Part B: Terms & Conditions

1. In accordance with Subsection 248(1) of the Income Tax Act, Aquilian Benefits Corporation (hereafter known as Aquilian Benefits) by this document establishes a “cost plus” PHSP with the Planholder named in Part A. Aquilian Benefits indemnifies the Covered Employees of the Planholder for all Eligible Expenses under the Plan. The Planholder agrees to fund the Plan by payment to Aquilian Benefits of agreed-upon "cost plus" fees.

2. The Aquilian Benefits PHSP applies to all Eligible Expenses. For this agreement Eligible Expenses are those defined in Subsection 118.2(2) of the Income Tax Act.

3. The Aquilian Benefits PHSP includes all Covered Employees as described by the Planholder in Appendix A - Eligible Claimant Information. The term Covered Employee includes the employee, the employee’s spouse or any member of the employee's household with whom the employee is connected by blood relationship, marriage or adoption.

4. The Planholder will establish an Effective Date after which coverage will begin under the plan. This date is the first day of any 12 month period ending in the current fiscal year. Further, each Covered Employee will be eligible for coverage from an eligibility date established by the Planholder in Appendix A - Eligible Claimant Information.

   Effective Date for this Plan _____

5. Each Covered Employee may be offered benefits under the Plan in differing levels of sponsorship based on position or critical importance within the firm. The Planholder may not limit participation in the Aquilian Benefits PHSP based solely on position as a shareholder. The Aquilian Benefits PHSP cannot be offered to one employee of a class while excluding an employee of the same class. The Planholder hereby establishes the following classes for use with Appendix A - Eligible Claimant Information:

Class A Limit of $_____/fiscal year for each Covered Employee in this class

Class B Limit of $_____/fiscal year for each Covered Employee in this class

Class C Limit of $_____/fiscal year for each Covered Employee in this class

Class D Limit of $_____/fiscal year for each Covered Employee in this class

Class E Limit of $_____/fiscal year for each Covered Employee in this class

6. Aquilian Benefits will adjudicate each claim submitted to ensure the following:

    a. The expenses are Eligible Expenses as per section 2
    b. The claimant is a Covered Employee as per section 3
    c. The claimed health services fall within the eligible dates as per section 4
    d. The annual authorized claim limit for the claimant is not exceeded as per section 5
    e. The claim has been properly completed, authorized and funded.

7. Upon completion of the claim adjudication, Aquilian Benefits will issue a reimbursement payment for the total cost of the Eligible Expenses to the claimant.

8. The agreed-upon Enrolment Fee is to be paid with this application. $NIL

PHSP Planholder:

Authorizing Signature: _____ Date: _____

Aquilian Benefits Corporation:

Authorizing Signature: _____ Date: _____

Optional: Did someone refer you to us? If so, who? _____

AQUILIAN

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*

Aquilian Benefits Corporation
2189 6th Concession Road
Uxbridge, ON L9P 1R4
Tel: (647) 333-7229

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*