FlexSave Catastrophic (Stop Loss) / Travel Medical Plan
Employee Enrollment Form

Employee Information

Company Name:		
Employee Name:		
Address:		
City:	**Province:**	**Postal Code:**
Date of Birth (Maximum Coverage under age 70) DD / MMM / YYYY	**Gender:** ☐ **Male** ☐ **Female**	

Coverage Details

☑	Plan Type	Annual Premium	Monthly Premium
	Single	**$100.00**	**$8.75**
	Couple	**$190.00**	**$16.65**
	Family	**$245.00**	**$21.50**
Effective Date of Coverage (all coverage begins on the 1st of the month selected)			MMM /YYYY

Dependent Coverage

Dependent Name	Gender	Date of Birth	Relationship
		DD/MMM/YYYY	
		DD/MMM/YYYY	
		DD/MMM/YYYY	
		DD/MMM/YYYY	

Premium Payment

☑	Payment Mode:	Payment Details
	Annual	**Cheque attached $**
	Monthly	**PAC Form and VOID Cheques must be submitted**

Signatures

Employee Signature:	
Employer Plan Administrator Signature:	
Date:	
Broker Name:	

FlexSave Division – HUB Financial Inc.
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Email: flexsave@hubfinancial.com