Innovative Benefits Inc.
435, 450 Ordze Road
Sherwood Park, Alberta T8B 0C5
e-mail: service@innovativebenefits.ca
Tel: (780) 448-0783
Fax: (780) 450-2507

ENROLLMENT FORM

EMPLOYER INFORMATION

Employer's Name: _____

Employer Address: _____

EMPLOYEE INFORMATION

Last Name: _____ First Name: _____

Email Address: _____ Date of Birth: _____

Home Phone: _____ Cell: _____

Date of Hire: _____

Home Address: _____ City: _____ Postal Code: _____

Occupation (Mandatory): _____

Choose your coverage: ◯ **Single Coverage** ◯ **Family Coverage** ◯ **Waive / No Coverage**

If family coverage is selected, are you or your dependents currently covered by another employer sponsored group Health or Dental Plan: ◯ Yes ◯ No

DEPENDENT INFORMATION

If applicable, please enter all dependent information. If the dependent is not a resident of the same province as you (the employee), please note their province.

Name	Date of Birth (M/D/Y)	Relationship	Are They Attending School Full Time?

Pursuant to the Private Health Service Plan agreement between Innovative Benefits Inc. and the above listed Employer, Innovative Benefits Inc. agrees to reimburse the above employee for eligible medical expenses incurred while the agreement and the employee's employment contract is in good standing. Expenses must be submitted during the plan year in which they were incurred or within the stated "run-off" period if after.
The following shall be considered on its own an employment agreement between the undersigned employee and the plan sponsor: The plan sponsor identified above agrees to indemnify the undersigned employee for eligible medical & dental expenditures incurred by the employee and their eligible dependents subject to the provisions as stated in the plan application and plan design form.

Employee Signature: _____ Employer Signature: _____

Date signed: _____ Date signed: _____

Innovative Benefits Inc. acknowledgement: _____

Admin Purpose only: Coverage Level: ◯ 1 ◯ 2 ◯ 3