Employer Application

FlexSave™

Client Account Information

Legal Business Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Phone: _____

Key Contact

Name: _____ Email: _____

Plan Information

Effective Date: _____ (DD/MM/YYYY)

Benefit Year: _____ (MM/YYYY - MM/YYYY)

Unused benefit to be: ☐ Forfeited ☐ Carry Forward Maximum ☐ Carry Forward Receipts
(Only ONE can be selected)

Plan Design

Employee Classification		Maximum Fixed Annual Benefit Amount		
Class Code	Class Level (ex: owner, executive, admin, laborer)	Health/Dental	Wellness	% Co-Pay*
A				
B				
C				
D				
E				

*Co-Pay percentage will default to 100% employer paid if not otherwise specified

$250.00 Non-refundable setup fee included: ☐ Cheque ☐ Credit Card

Authorized Person: _____ Authorized Signature: X _____

Advisor Name: _____ Advisor Signature: X _____

Advisor Email: _____ **Advisor will be included in email confirmation of plan registration.*

HUB

FlexSave™ Division – HUB Financial Inc. 1001, 3700 Steeles Avenue West, Woodbridge, ON L4L 8M9
Phone: 1 (800) 561-2405 (option 2) or Fax: 1 (866) 417-8394 | Email: flexsave@hubfinancial.com

Setup Fee Credit Card Payment

FlexSave™

Client Information

Company Name: _____

Contact Person: _____ Phone: _____

Broker Name: _____ Province: _____

Credit Card Information

Please charge $250.00 to my credit card as payment for FlexSave™ Set Up Fee

Card Type: ☐ MasterCard ☐ VISA

The following information should be submitted as it appears on your credit card statement:

Cardholder Name: _____

Address: _____
Street Number Street Name

Postal Code: _____

Card Number: | | | | | | | | | | | | | | | | |

Expiry: | | | | Security Code: | | |
MM YY

Signature: X _____

By signing you agree that the amount specified above will be charged to your credit card. If payment is rejected, your FlexSave™ application will not be processed.

Date: _____
DD/MMM/YYYY

Insert completed form in a separate envelope with FlexSave™ application
and mark attention FINANCE DEPT.
Courier is preferred method of sending credit card information
Credit card information will not be maintained by HUB Financial Inc.
Questions: call 1 (800) 561-2405 Option # 2 (FlexSave™)

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Employee Enrollment

FlexSave™

Employee Information

Company Name: _____

Employee Name: _____

Address: _____ City: _____

Province: _____ Postal Code: _____ DOB: _____
DD/MMM/YYYY

Email: _____ Gender: ☐ Male ☐ Female

Dependent Coverage (complete for couple or family coverage)

Dependant Name	Gender M/F	Date of Birth DD/MMM/YYYY	Relationship

FlexSave™ Coverage Information

Employee Class: _____ Annual Max: _____

Should first year benefit amount be pro-rated? ☐ Yes ☐ No Coverage Start Date: _____
DD/MMM/YYYY

Direct Deposit Bank Account Info

5 digit Branch # 3 digit Bank # Account #

Branch Number:	Bank Number:	Name of Bank:	Account Number:

Request for Direct Deposit

It is understood that:

- This banking information will be used for the sole purpose of depositing reimbursement.
- This information will be held in the Master File of the Company for which the employee is employed.
- HUB Financial Inc. reserves the right to pay the employee's reimbursement by cheque at any time.
- It is the sole responsibility of the employee to ensure the accuracy of the banking information on file. In addition, any subsequent changes in banking information must be reported in a timely fashion.
- HUB Financial Inc. may terminate payment by direct deposit without prior notice or authorization for the employee.

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July 2017

Catastrophic (Stop Loss) / Travel Medical Plan Enrollment

FlexSave™

Employee Information

Company Name: _____

Employee Name: _____

Select One:

☐ Company Contribution ☐ Employee Contribution

Payment Mode:

☐ Annually (Cheque) ☐ Monthly (PAD)

Coverage Details

STOP LOSS ENROLLMENT IS OPTIONAL
Please indicate plan requested.

Stop Loss*			
☑	Plan Type	Monthly	Annual
☐	Single	$10.22	$125
☐	Couple	$19.55	$240
☐	Family	$24.90	$305

*Coverage terminates at age 70

Stop Loss 70+*			
☑	Plan Type	Monthly	Annual
☐	Single	$19.56	$240
☐	Couple	$36.92	$450
☐	Family	$42.15	$510

*Coverage terminates at age 75

Effective Date of Coverage: (all coverage begins on the 1st of the month selected) _____
MMM /YYYY

Premium rates are provided for information only. Premium will be paid in accordance with plan setup.

Pre-Authorized Debit Details / Bank Account Information

Please attach a VOID cheque

I/We authorize HUB Financial Inc., and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments to pay premium due for Stop Loss / Travel Medical Insurance premiums on or about the 15th day of each month.

This authority is to remain in effect until HUB Financial Inc. has received written notification from me/us of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled at the address provided below.

I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.cdnpay.ca.

HUB Financial reserves the right to assess a charge for handling of a dishonored PAD.

Banking Information Already Provided: ☐

Account Number: | | | | | | | | | | | | | | |

Branch Transit Number: | | | | | |

Financial Institution Number: | | | |

Financial Institution Name: _____

Branch Address: _____

Signature of Account Holder: X _____

Name of Account Holder: _____

Signature of Joint Account Holder (if applicable): X _____

Name of Joint Account Holder (if applicable): _____

Date: _____
DD/MMM/YYYY

I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement of any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca.