



CLIENT GENERAL INFORMATION

FULL LEGAL NAME OF COMPANY

BUSINESS ADDRESS

CITY

PROVINCE

POSTAL CODE

TELEPHONE NO. ALTERNATE NO.

FAX NO. WEBSITE ADDRESS

ADMINISTRATOR CONTACT EMAIL

CONTRACT CONTACT EMAIL

CORRESPONDENCE CONTACT EMAIL

CORRESPONDENCE CONTACT ADDRESS

CITY

PROVINCE

POSTAL CODE

LEGAL STATUS CORPORATION ASSOCIATION OTHER

PLAN SPONSOR CONTRIBUTION [MINIMUM 50%] % HEALTH + DENTAL

DOES THIS COVERAGE REPLACE AN EXISTING PLAN? YES NO IF "YES", CURRENT BENEFIT PROVIDER 

Application is hereby made for Health and Dental benefits through PayTrak Payroll Services Ltd. It is understood that the contract will not provide benefit coverage prior to being approved and accepted. Any existing coverage should not be cancelled until this application is approved.

EFFECTIVE DATE

This agreement shall be Effective from 12:01 a.m. from the 1st day of

This agreement may be renewed thereafter in accordance with the terms of the contract.

Initial Debit Amount for Deposit \$ [WRITTEN]

NAME OF AUTHORIZED OFFICER TITLE

SIGNATURE DATE [YEAR | MONTH | DAY]

NAME OF AUTHORIZED OFFICER TITLE

SIGNATURE DATE [YEAR | MONTH | DAY]