APPLICATION FOR HEALTH SPENDING ACCOUNT

Mailing Address:
PO Box 7000, Vancouver, BC V6B 4E1
Street Address:
4250 Canada Way, Burnaby, BC
Fax: 604 419-2149

for PBC office use only

Employer/Plan Administrator - Complete this section

HSA Group Number
ID Number (e.g., SIN)
Effective Date (mm/dd/yy)

Applicant - Complete this section

Surname	First name	Middle initial	Birthdate (mm/dd/yy)	Sex
				❑ M ❑ F

Address	City	Province	Postal Code

Dep. no.	Surname* (* not required if same as yours)	First name	Middle initial	Birthdate (mm/dd/yy)	Sex	Relationship to you
01	Spouse				❑ M ❑ F	
02	1st child/dependent				❑ M ❑ F	
03	2nd child/dependent				❑ M ❑ F	
04	3rd child/dependent				❑ M ❑ F	
05	4th child/dependent				❑ M ❑ F	
06	5th child/dependent				❑ M ❑ F	

(Use reverse side for additional dependents) ❑ I have listed dependents on the reverse side

I understand that a Health Spending Account (HSA) will be established and funded by the plan sponsor for my benefit, and for the benefit of individuals I claim as dependents under the HSA. I am aware that Pacific Blue Cross (PBC) must administer the HSA in accordance with the Income Tax Act of Canada and I agree to abide by its legal requirements. I also agree to the conditions of the contract between the plan sponsor and PBC (the contract) and I confirm that all dependents I claim under this HSA are eligible under the terms of the contract. By providing my Social Insurance Number, I authorize PBC to use it for identification purposes only. I confirm that the information I have provided is true and complete. I understand that this HSA will not reimburse expenses that are normally covered by the Provincial Medical Plan. I understand and consent to my personal information being dealt with by PBC in accordance with its Privacy Policy in effect from time to time. A copy of the privacy policy is available by contacting PBC. It is also available at www.pac.bluecross.ca

X Signature of applicant _______________ Date (mm/dd/yy)

Employer/Plan Administrator- Complete this section

Name of company/organization	Department code	Employee number

Deposit amount per cycle	Annual election	Date of hire (mm/dd/yy)
$ ____________	$ ____________	

If we have questions about this application, how can we contact you: ❑ phone ____________ ❑ e-mail ____________

On behalf of the Employer/Plan Administrator, I request PBC to open an HSA for this applicant.

X Signature of Employer/Plan Administrator _______________ Date (mm/dd/yy)

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