THE HEALTH SPENDING ACCOUNT PLUS PLAN

BENEFIT SOLUTIONS FOR PROFITABLE ENTREPRENEURS

Administered by

the benefits trust

3800 Steeles Avenue West, Suite 102W
Vaughan, Ontario L4L 4G9
416-498-7723 or 905-264-8990
www.thebenefitstrust.com

THE HEALTH SPENDING ACCOUNT PLUS PLAN

The Health Spending Account Plus Plan combines the flexibility of Health Care Spending Accounts with catastrophic event insurance for additional protection, for groups with one or more full time employees. This plan enables you (and your employees, if any) to choose where to spend your benefit dollars, without the limitations of many traditional benefits plans.

Opportunity

- To pay all medical and dental expenses for you and your family through your business with pre-tax dollars.
- To provide employees with a flexible, tax effective employee benefits plan within your budget.

Method

- Join the Health Spending Account Plus Plan to pay for all these expenses on a tax effective basis, with a Health Care Spending Account.

What is a Health Care Spending Account?

- A Health Care Spending Account is a pre-determined amount of money provided to employees at the beginning of each benefit year for coverage of their medical and dental expenses.
- This amount is held in trust. Claims are submitted by you (and your employees if any) and reimbursed in a similar fashion to a traditional benefits plan.
- Eligible expenses are reimbursed at 100% up to the total dollar amount available in the HCSA.

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How The Plan Works

- Estimate your family's expected medical and dental expenses for the next year. A detailed list of eligible expenses is included in the Participation Agreement which accompanies this application.
    - Include in your estimate: repeat prescription drug expenses, regular dental check-ups, orthodontics or dental implants, eye glasses, contact lenses, or laser eye surgery, chiropractic and massage therapy expenses, and any other expected medical or dental expenses.
- Minimum annual contribution $3,000 for you and your family.
- Divide the expected annual expenses by 12 to determine your monthly funding requirement (minimum $250 per month). You may want to add a margin for unexpected expenses.
- Deposit the first month's contribution plus the appropriate taxes and administration charges into your specific trust account, which is maintained and administered by The Benefits Trust. A worksheet is included with this package.
- On-going monthly contributions will be automatically withdrawn from your bank account. A pre-authorized payment form is included with this application.
- Claim against your trust account for reimbursement as you and your family incur medical and dental expenses.
- You can add a separate Health Care Spending Account for each employee (if applicable), with an annual amount that meets your budget. No minimum is required for employees.

Taxation

- 100% of the deposits into the Health Spending Account Plus Plan, including administration and applicable taxes, are tax deductible business expenses. This includes deposits for both you and your employees.
- All benefits received are non-taxable to the individual.

Administration Fee per Health Care Spending Account

- 15.0% administration fee per year charged on HCSA contribution amount
- Plus applicable taxes (Ontario):
  2.0% premium tax charged on HCSA contribution and administration
  8.0% provincial insurance tax charged on HCSA, administration, and insurance premiums
  13.0% HST charged on administration fee and premium tax

Please contact our office with any questions about applicable taxes in other provinces.

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Catastrophic Event Insurance Protection

Out of Country Emergency Medical Care

- Insurance coverage for reasonable and customary charges in the area where the emergency occurred, in the event of a sudden, unexpected illness or injury during the first 60 days of travel for business or pleasure. This plan includes hospital care, physician's services, and other appropriate standard medical treatment.
- Maximum $5,000,000 per covered person in their lifetime.
- Supplementary Travel Assist Services are provided for personal or medical emergencies.
- Underwritten by Expert Travel Financial Security (E.T.F.S.) Inc.

Excess Medical Stop Loss Insurance

- Supplemental Insurance protection for catastrophic in-Canada Health Care claims in excess of $5,000 per person per year. Coverage includes Semi-private hospital room, Private Duty Nursing, Convalescent Home care and Prescription Drugs. This plan also covers each person for recurring treatments.
- A standard 12/24 month pre-existing conditions clause applies to all participants in this plan.
- Maximum $1,000,000 per covered person in their lifetime.
- Underwritten by Expert Travel Financial Security (E.T.F.S.) Inc.

Annual Premium for Catastrophic Event Insurance Protection

Includes both Out of Country Emergency Medical Care and Excess Medical Stop Loss Insurance

Single:	$16.00 per month
Family:	$32.00 per month

HEALTH SPENDING ACCOUNT PLUS PLAN
Enrollment Form

Corporate Information

Company Name

_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____ Email: _____

Personal Information

☐ Mr. ☐ Mrs.

Last Name: _____ First Name: _____ ☐ Ms. ☐ Miss

Address: _____ Apt. # _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: (Month) _____ (Day) _____ (Year) _____ S.I.N. : _____ - _____ - _____

Sex: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Common Law ☐ Length of C/L Relationship: _____

Dependant Information

Please list all dependants including your spouse, common-law spouse (relationship of at least one year), and/or children. Children are eligible if under age 21, or under age 26 and attending school full time, or disabled and completely dependent on you for support. Complete an "**Overage Dependant**" form if applicable.

	Last Name	First Name		Date of Birth (Month)	(Day)	(Year)
Spouse			☐ M ☐ F			
	Child's Last Name	**First Name**		**(Month)**	**(Day)**	**(Year)**
1.			☐ M ☐ F			
2.			☐ M ☐ F			
3.			☐ M ☐ F			
4.			☐ M ☐ F			

Selection of Coverage

Annual HCSA: _____ Benefit Year Beginning: (Month) _____ (Day) 01 (Year) _____

Member's Authorization

I hereby apply for the benefits for which I am or may become eligible, subject to any waiver indicated, under the Participation Agreement issued by The Benefits Trust and authorize that any required contributions be deducted from my earnings. In addition, I authorize The Benefits Trust and its administrators to use my social insurance number, if applicable, for identification purposes in the administration of the benefits plan. On behalf of myself and my dependents, I also authorize The Benefits Trust (including its affiliates and/or insurance partners) to exchange the information detailed in this Enrollment and any other benefit related information contained in files regarding me or my dependents, now or in the future, for the purposes of administration and/or management of the Participation Agreement issued by The Benefits Trust. I have not received tax advice from The Benefits Trust, it administrators, or any of its agents.

Member's Signature: _____ Date: (Month) _____ (Day) _____ (Year) _____

Application Checklist

Submission Guidelines

Minimum $3,000 in annual HCSA funding for participating member. No minimum funding requirement for employees (if applicable).

Member (and eligible employees if any) must work a minimum of 20 hours per week.

Complete applications received at The Benefits Trust on or before the 15th of the month will take effect the first of the following month.

NOTE: Incomplete applications will not be processed until all materials are received at The Benefits Trust.

The following materials are enclosed (√) with this submission:

- ❑ Premium Calculation Worksheet and Premium Deposit for $ _____
- ❑ Enrollment Forms for member & eligible employees. Number enclosed: _____
- ❑ Participation Agreement, completed and signed by member.
- ❑ Pre-Authorized Payment Form with Void cheque.

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Broker / Agent Information and Declaration

Name of Client: _____

Broker / Agent Name: _____

Title: _____

Broker / Agent Corporate Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Email: _____

Agent Signature: _____ Date: _____

For internal use only

Agent Number: _____

Broker EFT Received:

_____