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Appendix A: Eligible Employees

This form constitutes an amendment to the Health Spending Account (HSA, Private Health Services Plan, PHSP) Registration Agreement. This form can also be used to make any changes to the list of your Covered Employees. **Note: Unincorporated businesses must complete Appendix C – Family Members as well as listing arms-length employees on this form.**

Business Name (Planholder): _____

1. Employee Name: _____ Add Update Delete

Postal Address: _____

Email Address: _____ Phone: _____

Eligibility Date: _____ Class: _____ Direct Deposit? _____ (attach VOID cheque.)

2. Employee Name: _____ Add ____ Update ____ Delete ____

Postal Address: _____

Email Address: _____ Phone: _____

Eligibility Date: _____ Class: _____ Direct Deposit? _____ (attach VOID cheque.)

3. Employee Name: _____ Add ____ Update ____ Delete ____

Postal Address: _____

Email Address: _____ Phone: _____

Eligibility Date: _____ Class: _____ Direct Deposit? _____ (attach VOID cheque.)

4. Employee Name: _____ Add ____ Update ____ Delete ____

Postal Address: _____

Email Address: _____ Phone: _____

Eligibility Date: _____ Class: _____ Direct Deposit? _____ (attach VOID cheque.)

5. Employee Name: _____ Add Update Delete

Postal Address: _____


Email Address: _____ Phone: _____

Eligibility Date: _____ Class: _____ Direct Deposit? _____ (attach VOID cheque.)

IF MORE THAN 5 EMPLOYEES PLEASE ATTACH ANOTHER SHEET.



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