Direct Reimbursement Associates Ltd.

Toll-Free: 1.866.275.1610 Cell: 403.632.5226 Toll-Free FAX: 1.855.209.9374 Email: admin@draltd.com
PO Box 388, Pincher Creek, Alberta T0K 1W0

Health Spending Account (Private Health Services) Plan Registration Form

Part A: Planholder

Company or business name:_____

(corporate name, partnership or sole proprietorship)

Is the business incorporated? Yes:☐ No:☐ (If No, please complete Appendix C – Family Members)

Mailing Address: _____

_____

Fiscal Year End: _____ (Month and Day)

Contact Person: _____ Phone:_____

Contact Email Address: _____

Alternate Contact Person: _____ Phone: _____

Alternate Contact Email Address: _____

Part B: Terms & Conditions

1. In accordance with Subsection 248(1) of the Income Tax Act, Direct Reimbursement Associates Ltd. (hereafter known as DRAltd) by this document establishes a "cost plus" Private Health Services Plan ("Plan"), also known as a Health Spending Account (HSA) Plan, with the Planholder named in Part A. DRAltd indemnifies the Covered Employees of the Planholder for all Eligible Expenses under the Plan. The Planholder agrees to fund the Plan by payment to DRAltd of agreed-upon "cost plus" fees.

2. The DRAltd Plan applies to all Eligible Expenses. For this agreement Eligible Expenses are those defined in Subsection 118.2(2) of the Income Tax Act. A direct link to the legislation and associated interpretive documentation is available on the website (www.draltd.com).

3. The DRAltd Plan includes all Covered Employees as described by the Planholder in Appendix A - Eligible Employees. The term Covered Employee includes the employee, the employee's spouse or any member of the employee's household with whom the employee is connected by blood relationship, marriage or legal adoption.

4. The Planholder hereby establishes an Effective Date upon which coverage will begin under the Plan. This date is the first day of any 12-month period ending in the current fiscal year. Further, each Covered Employee will be eligible for coverage from an Eligibility Date established by the Planholder in Appendix A - Eligible Employees.
The Effective Date for this Plan is: _____

5. Each Covered Employee shall be offered benefits under the Plan at a level determined by the Planholder. The Planholder ***may not*** limit participation in the DRAltd Plan based solely on position as

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a shareholder. The DRAltd Plan cannot be offered to one employee of a designated class while excluding another employee of the same class. Sole Proprietorships are not eligible for Class A – Unlimited Coverage. The Coverage for sole proprietorships is identified in Appendix C - Family Members.

The Planholder hereby establishes the following classes for use with Appendix A - Eligible Employees:

Class A Unlimited Coverage (for executives of incorporated businesses only)
Class B Limit of $_____/fiscal year for each Covered Employee in this class
Class C Limit of $_____/fiscal year for each Covered Employee in this class
Class D Limit of $_____/fiscal year for each Covered Employee in this class
Class E Limit of $_____/fiscal year for each Covered Employee in this class
Class F Limit of $_____/fiscal year for each Covered Employee in this class

6. DRAltd will adjudicate each claim when submitted to ensure the following:

a) The expenses are Eligible Expenses as per section 2.
b) The claimant is a Covered Employee as per section 3.
c) The claimed health services fall within the eligible dates as per section 4.
d) The annual authorized claim limit for the claimant is not exceeded as per section 5.
e) The claim has been properly completed, authorized and funded.

7. Upon completion of the claim adjudication, DRAltd will issue a reimbursement payment for the total cost of the Eligible Expenses to the claimant.

8. DRAltd will provide timely reporting, including an Annual Client Statement for tax purposes, as required and appropriate for the Planholder to reconcile all transactions in the accounts of the Planholder and the Covered Employee(s) for the fiscal year.

9. The agreed-upon Plan Registration Fee to be paid with this application is: _____

Planholder:

Authorizing Signature: _____Date: _____

Direct Reimbursement Associates Ltd. (For Office Use Only)**:**

Authorizing Signature: _____ Date: _____

Plan Number: _____

Referral Source: Please tell us who we can thank: