

THE EMPLOYMENT BENEFIT PLAN

Elite Business Services Ltd.

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PRIVATE HEALTH SERVICES PLAN { PHSP } ENROLLMENT FORM

Business Name:		Level *:	
Corporation #: * - if applicable		Year End:	
Address:			
City:		Postal Code:	
Phone:	Fax:	Number of Employees:	
Contact Person:			
Referred by:			

1. In accordance with subsection 248(1) of the Income Tax Act, Elite Business Services Ltd. by this document establishes a “*cost plus*” PHSP with the Plan holder named above. Elite Business Services indemnifies the Covered Employees of the Plan holder for all Eligible Expenses under the plan. The Plan holder agrees to fund the plan by payment to Elite Business Services Ltd. of agreed-upon “cost plus fees.
2. Elite Business Services Ltd. PHSP 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 EliteBenefits.ca website
3. Elite Business Services Ltd. PHSP includes all Covered Employees as described by the Plan holder Eligible Claimant Information. 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 Plan holder will establish and Effective Date after 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 Plan holder – Eligible Claimant Information.

Effective Date for this Plan: _____

5. Each Covered Employee shall be offered benefits under the plan in differing levels of sponsorship based on the Employers discretion.
6. Elite Business Services Ltd. will provide timely reporting, including an annual client statement for tax purposes, as required and appropriate for the Plan holder to reconcile all transactions in the accounts of the Plan holder and the covered Employees for the fiscal year.
7. The agreed-upon registration fee is to be paid with this application \$ _____ per: _____

PHSP Plan holder: _____ **Date:** _____

Authorizing Signature