QUIKCARD™

Innovative Benefits Solutions

Adult Dependent Declaration

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Company Name (Employer) _____

Cardholder's Name _____

Group Number _____

Cardholder's Number _____

I HEREBY CONFIRM that _____, for the purposes of the medical expense
(the "person")

tax credit, qualifies as a "dependent" of the cardholder because all the following conditions are met:

a) The person is the child, grandchild, parent, grandparent, brother, sister, uncle, aunt, niece or nephew of the cardholder or of the cardholder's spouse.
b) The person is dependent on the cardholder for support at some time in the year.
c) The person is a resident of Canada at some time in the year. This residence requirement does not apply if the person is the child or grandchild of the cardholder or of the cardholder's spouse.

DECLARATION: The undersigned each declare that all information and statements in this Adult Dependent Declaration form are true and complete. Each of the Employer and the Cardholder are responsible for informing Quikcard Solutions Inc. of any inaccuracy or change in the information provided on this form or the discontinuation of qualification for the above mentioned dependent. The information requested on this form is required for benefit administration purposes. For more information consult Quikcard's privacy policy at www.quikcard.com/privacy-policy/ or contact Quikcard by phone or mail

_____ _____

Cardholder's Signature | Employer's Signature

_____ _____

Date | Date