Application Form

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quikcard.com

Company Name (The Applicant) ______________________ **Contact** ______________

Address ____

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Phone ____________ **Fax** ____________ **Email** ______________

Proposed Effective Date ______________ **How did you hear about us?** ______________

Total # of Employees ______________ **Total # of Dependents** ______________

Dental Coverage	**Existing Plan**	**Proposed Plan**
Deductible		
Basic Services (exams, fillings, etc.) (%)		
Major Services		
Orthodontic Coverage (%)		
Annual Maximum ($)		
Vision Coverage (%)		
Annual Maximum ($)		

Health Services (including, but not restricted to Psychological Services, Accupuncture, Massage Therapy, Medical Services and Equipment, Ambulance Services, Hospital Accomodations, Other)

Health Service Coverage (%)		
Annual Maximums ($)		
Employee & Family Assistance Programs (%)		
Annual Maximum ($)		
Drug Card (%)		
Annual Maximum ($)		

Additional Information ____

The undersigned declares that the above information is true and complete and that the undersigned is authorized to sign this application on behalf of the Applicant. The information collected on this form and otherwise in connection with this application is required by Quikcard Solutions Inc. ("Quikcard") for benefit administration purposes, including to assess and process this application; to administer any benefit plan if approved and to enforce any obligation owed by the Applicant to Quikcard. The undersigned authorizes Quikcard to collect, use, and exchange, for benefit administration purposes, additional information about the Company (including its principals) and its/their credit worthiness, from and with references; personal information and credit reporting agents, credit reporting bureaus; and other institutions with whom any of it or them may have financial dealings, now or at any time in the future. For more information consult Quikcard's privacy policy at www.quikcard.com/privacy-policy/ or contact Quikcard by phone or mail.

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Signature Title Date