Quikcard

V2023120120

CARDHOLDER ENROLLMENT / UPDATE

INSTRUCTIONS: Please do not forget to sign and date this form.	**IMPORTANT:** This claim form will be returned if incomplete or unsigned.	**COMPLETED FORM:** Can be mailed, faxed, or emailed to admin@quikcard.com.

Action	Effective Date (D/M/Y)
☐ New Primary Cardholder ☐ Change Information ☐ Terminate Primary Cardholder	

1. Cardholder Information

Employer Name ____________ Group # ____________ Division # ____________

Name ____________ Card # (if not a new cardholder) ____________

Address ____________ City ____________ Province ____________ Postal Code ____________

Date of Birth (D/M/Y) ____________ Gender ____________ Phone # ____________ Email Address ____________

2. Dependent Information

Action	Relationship to Cardholder	Name	DOB (D/M/Y)	Gender	Overage Dependent*
☐ Add ☐ Change ☐ Delete	☐ Spouse ☐ Dependent				☐ Post Secondary Student ☐ Adult Dependent
☐ Add ☐ Change ☐ Delete	☐ Spouse ☐ Dependent				☐ Post Secondary Student ☐ Adult Dependent
☐ Add ☐ Change ☐ Delete	☐ Spouse ☐ Dependent				☐ Post Secondary Student ☐ Adult Dependent
☐ Add ☐ Change ☐ Delete	☐ Spouse ☐ Dependent				☐ Post Secondary Student ☐ Adult Dependent
☐ Add ☐ Change ☐ Delete	☐ Spouse ☐ Dependent				☐ Post Secondary Student ☐ Adult Dependent

**If yes, please fill out either the Education Status Update or the Adult Dependent Declaration form*

3. Coordination of Benefits

Do you or your spouse have any other coverage? ☐ Yes ☐ No

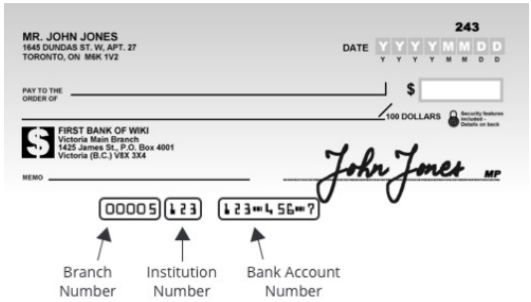
If yes, please indicate type of coverage: ☐ Dental ☐ Health ☐ Vision ☐ Drug ☐ HSA

Name of other insurance plan or carrier: _____

4. Banking Information

Claim reimbursements will be directly deposited to this account.

Action
☐ New
☐ Change
☐ Terminate



Name of Bank

Branch Address | City | Province | Postal Code

Branch Number | Institution Number | Bank Account Number

Please attach a void cheque with this form

AUTHORIZATION: I authorize Quikcard Solutions Inc. ("Quikcard") to credit the account identified (the "Account") for payments administered by Quikcard in respect of treatment claims. Each payment shall be the same as if I had personally received a cheque from Quikcard and deposited it to the Account. I will update the Account promptly if I move the Account from my Bank or branch to another, or if there is any other change in the Account. This authorization may be cancelled at any time upon written notice by me to Quikcard. Any delivery of this authorization to Quikcard constitutes delivery by me to my Bank. I am the person who is authorized to sign on the Account.

5. Disclaimers

PRIVACY NOTICE: The information requested in respect of this form is required by Quikcard for benefits administration purposes. For these purposes Quikcard will, where necessary, collect from and exchange information with others. For more information, consult Quikcard's privacy policy or contact Quikcard by phone or mail.

DECLARATION: I declare that all information and statements in this Cardholder Enrollment / Update 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 of the above-mentioned dependant.

Signature of Cardholder | Date