Quikcard

V2024112222

CARDHOLDER INFORMATION FORM

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

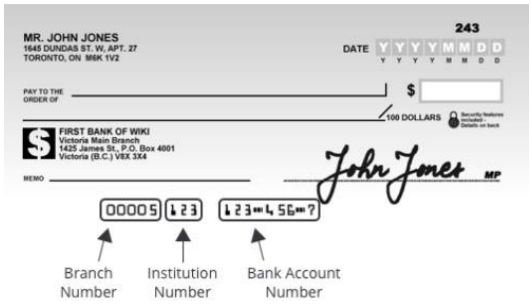
If yes, please indicate type of coverage: ☐ Dental ☐ Health ☐ Vision ☐ Drug ☐ HSA

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. FlexPlan Allocation

Please enter two values: one for your Health Spending Account (HSA) and one for your Wellness Spending Account (WSA). Each value must be a percentage between 0% and 100%, in increments of 5% (e.g., 40% or 45%). The total of both values must equal 100%.

Note: *Please check with your Plan administrator for the minimum and maximum % allocation limits. If outside of allowable range, default plan allocations selected by Plan administrator will be used instead.*

HSA | WSA

6. 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