



ENROLLMENT FORM

200 QUIKCARD CENTRE
 17010 - 103 AVENUE
 EDMONTON, AB T5S 1K7
 PHONE (780) 426-7526
 FAX (780) 426-7581
 TOLL FREE 1-800-232-1997

Company Name _____ Contract # _____

Name _____

Effective Date _____ New Change of Address Add Dependent Delete Dependent Termination

S.I.N. _____ D.O.B. _____ Sex _____

Address _____

DEPENDENTS

	NAME	D.O.B.			SEX
		D	M	Y	
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					

Please Indicate Type of Coverage Dental Vision Health Services Drug Card Employee & Family Assistance Program
 Do you or your spouse have any other coverage? Yes No
 Name of Other Insurance or Plan Carrier _____

Quikcard Solutions must collect and retain certain personal information in order to provide our services to you. Protecting your privacy is important to us. Accordingly we have established this Privacy Statement and a Confidentiality Agreement for our employees to ensure that your personal information remains confidential.

The Personal Information We Retain

We require personal information in order to provide you with the health plan administrative services your employer has contracted with us to provide. Our files contain your enrollment information and your health claims history from your time of enrollment. Your file may also include correspondence for your coverage and copies of correspondence or information filed with respect to any claims you make.

How We Use This Information

We only collect information that is necessary to provide you with the benefits of participation in the health plan provided to you by your employer, and subject to statutory requirements, we retain this information only as long as necessary to provide you with these services. Specifically, we utilize this information to determine your eligibility for benefits under the health plan rules designed by your employer. Your personal information is not developed into a mailing list of any kind.

Who Has Access To This Information

We restrict access to your personal information to those of our employees who need such information to do their jobs. Those individuals are subject to our Confidentiality Agreement that specifies rules for protecting the confidentiality of your personal information. We may also provide information to health care professionals to facilitate the payment of your claims under the provisions of the Health Plan designed by your employer.

Your Access To Our Information

Subject to the exceptions* described below, you may review the personal information contained in your file and, if necessary, ask for corrections to be made to it, by making a written request to:

Quikcard Solutions Inc.
 200 Quikcard Centre
 17010 - 103 Avenue
 Edmonton, AB T5S 1K7

*We will not provide you with information that may be subject to a legal claim of privilege. If your file contains claims information about you that was not obtained directly from you, that information may only be released to you through your health care professional who initially provided us with the information. In addition, if your plan provides coverage for someone else, such as your spouse, your file may contain information about the other person. In such a case we will only provide you with access to the information about you unless the other person gives written consent to our disclosure of their information to you.

I authorize that my Social Insurance number may be used by Quikcard Solutions Inc. as administrator of my benefits as my personal identification number (cardholder ID number) for claims information and billing records for me and my dependents.
 Yes No

 Signature

 Date