CustomCare™

Employee Opt-Out Form

VERIFICATION OF EMPLOYEE	
COMPANY NAME	DATE DD / MM / YYYY
EMPLOYEE'S NAME	DATE OF BIRTH DD / MM / YYYY
ADDRESS	CITY
PROVINCE	POSTAL CODE

Please read and check that the following:

☐ I have chosen not to participate in the CustomCare Tailored Health Care plan that my employer, has enrolled in.

☐ I understand that the CustomCare plan allows participants to be reimbursed for medical and dental expenses up to the maximum spending limit the employer decides to allocate. I also understand that this benefit would be passed on to me tax-free, is entirely employer funded and that there would be no cost to me if I did choose to participate.

Please do not include me in my employers CustomCare plan.	
EMPLOYEE'S SIGNATURE	DATE DD / MM / YYYY

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