

<b>Health Spending Account - Certificate of Coverage</b>		
First Name <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	Middle Name	Last Name
Street Address		City
Province (residence)	Postal Code	Province (employment) <input type="checkbox"/> Same
First day of Coverage	Monthly Deposit \$	First Deposit Amount \$ <input type="checkbox"/> Same
Year-end Procedure <input type="checkbox"/> Deposit Carry-forward <input type="checkbox"/> Claim Carry-forward	Plan Sponsor:  Signature: _____ Date: _____	

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