PHSP REGISTRATION FORM B:

Eligible Claimant Information

Please complete the following fields for each eligible claimant/employee. If more than 4 employees, you can request an Excel template from AVFS for easier entry.

Employer Name

Employee Last Name:		Employee First Name:	
Employee Mailing Address:			
City:	Province:	Postal Code:	Phone Number:
Email Address:			PHSP Start Date:
PHSP Eligible Date:	Coverage Class: ☐ A ☐ B ☐ C ☐ D ☐ Other:____		Eligible Dependents? ☐ Yes ☐ No

Employee Last Name:		Employee First Name:	
Employee Mailing Address:			
City:	Province:	Postal Code:	Phone Number:
Email Address:			PHSP Start Date:
PHSP Eligible Date:	Coverage Class: ☐ A ☐ B ☐ C ☐ D ☐ Other:____		Eligible Dependents? ☐ Yes ☐ No

Employee Last Name:		Employee First Name:	
Employee Mailing Address:			
City:	Province:	Postal Code:	Phone Number:
Email Address:			PHSP Start Date:
PHSP Eligible Date:	Coverage Class: ☐ A ☐ B ☐ C ☐ D ☐ Other:____		Eligible Dependents? ☐ Yes ☐ No

Employee Last Name:		Employee First Name:	
Employee Mailing Address:			
City:	Province:	Postal Code:	Phone Number:
Email Address:			PHSP Start Date:
PHSP Eligible Date:	Coverage Class: ☐ A ☐ B ☐ C ☐ D ☐ Other:____		Eligible Dependents? ☐ Yes ☐ No

Submit