Member Request for Implementation

Member & Family Assistance Program (MFAP)

(PLEASE PRINT)

Policy Holder/Client: ☐ YES A&S Policy # VFP________________ ☐ NO

Applicant Information

Legal Organization Name: ____________________

Street Address ____________________

City ____________ Province ____________ Postal Code ____________

Phone ( ) ____________ Fax ( ) ____________

Number of Eligible Members ________________________

All Members must be covered. Describe any employees within the organization that are not eligible for any coverage under the MFAP ____________________

MFAP Contact Name ____________________

MFAP Contact Title: ____________________

MFAP Contact Address (if different than above) ____________________

MFAP Contact Phone ( ) ____________ Fax ( ) ____________

MFAP Contact Email Address ____________________

Declaration

Effective ______________, 20___ the applicant, ____
(insert full legal organization name)

hereby requests CVIS, Inc. to implement the Homewood Health Member & Family Assistance Program (per a master Agreement between CVIS, Inc. and Homewood Health dated January 1, 2015) on our behalf for an initial one (1) year term. We hereby agree to the monthly cost as presented by CVIS, Inc. (Member: $3.00 per month, Non-member: $4.00 per month), and consent to being billed by Homewood Health in advance, on an annual basis. We understand that member eligibility will be based on the same criteria as our group insurance program, unless otherwise contracted with CVIS, Inc. This agreement shall be automatically renewed for consecutive one (1) year terms, at the applicable CVIS,Inc. member/non-member rate, unless the Applicant provides a minimum of thirty (30) days written notice of cancellation to CVIS, Inc. or Homewood Health.

________________________________ ________________________________
Date Signature of Authorized Signatory

____
Title

________________________________ ________________________________
Date Signature of VFIS of Canada (CVIS, Inc) Agent