



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: \$2.00 per month, Non-member: \$3.00 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 _____