CPA INSURANCE PLANS WEST

STAFF ENROLLMENT APPLICATION

FOR CPAIPW USE ONLY: CERT # _____ LIFE _____$ AD&D _____$ LTD _____$ CI _____$

PLEASE PRINT CLEARLY AND COMPLETE ALL PAGES OF THIS FORM, IN INK. SECTION 1 IS TO BE COMPLETED BY THE PLAN ADMINISTRATOR AND SECTIONS 2 THROUGH 7 ARE TO BE COMPLETED BY THE PLAN MEMBER. KINDLY KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS AND SEND THE ORIGINAL TO CPAIPW 9918A 102 STREET, FORT SASKATCHEWAN, AB T8L 2C3

1. EMPLOYER SECTION

THIS SECTION IS TO BE COMPLETED BY THE PLAN ADMINISTRATOR.

ADD EMPLOYEE ☐

CHANGE EMPLOYEE ☐

PLAN NUMBER: 56579 FIRM NUMBER: ☐☐☐☐ FIRM NAME: _____

FIRST DATE OF EMPLOYMENT: MONTH _____ DAY _____ YEAR _____

EFFECTIVE DATE OF COVERAGE/CHANGE: MONTH _____ DAY _____ YEAR _____

NOTE: CPAS ELIGIBLE ON FIRST DAY OF EMPLOYMENT; NON-CPAS ELIGIBLE 3 MONTHS AFTER DATE OF EMPLOYMENT UNLESS OTHERWISE ADVISED

EARNINGS (BEFORE TAX): $_____ PER YEAR ☐ MONTH ☐

STATUS: CPA EMPLOYEE ☐ NON-CPA EMPLOYEE ☐ PARTNER ☐ STUDENT ☐

CPA MEMBER NUMBER (IF APPLICABLE): _____

2. PLAN MEMBER INFO

THIS SECTION IS TO BE COMPLETED BY THE PLAN MEMBER.
PLEASE PRINT CLEARLY IN INK

PLAN MEMBER NAME (PRINT): _____

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____

EMAIL: _____ PHONE NUMBER: _____

PLAN MEMBER MAILING ADDRESS:

STREET ADDRESS: _____

CITY: _____ PROV: _____ POSTAL CODE: _____

MARITAL STATUS: MARRIED COMMON-LAW SINGLE

DO YOU HAVE DEPENDENT CHILDREN, INCLUDING FULL TIME STUDENTS OR DISABLED ADULTS? YES ☐ NO ☐

DO YOU USE TOBACCO PRODUCTS OR HAVE EVER USED? YES ☐ NO ☐

DATE STOPPED: MONTH _____ DAY _____ YEAR _____

3. BENEFICIARY DESIGNATION

THIS SECTION MUST BE COMPLETED TO DESIGNATE A BENEFICIARY FOR YOUR LIFE BENEFITS.
THE ORIGINAL OF THIS FORM WILL BE REQUIRED FOR A LIFE CLAIM. CROSSED OUT BENEFICIARY DESIGNATIONS MUST BE INITIALED. DO NOT USE WHITE-OUT OR CORRECTION FLUID. PLEASE PRINT CLEARLY IN INK.

BENEFICIARY NAME(S)			PERCENT ALLOCATED	RELATIONSHIP TO PLAN MEMBER
LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____	_____	_____
LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____	_____	_____
LAST NAME _____	FIRST NAME _____	MIDDLE INITIAL _____	_____	_____

TO BE DIVIDED AS FOLLOWS: AS PER THE PERCENTAGE INDICATED ABOVE, OR ☐

IN EQUAL SHARES TO SURVIVOR(S) ☐

TRUSTEE NAME (TO BE COMPLETED IF YOU ARE DESIGNATING A CHILD UNDER AGE 18)

LAST NAME _____ FIRST NAME _____ RELATIONSHIP TO PLAN MEMBER _____

4. DEPENDENT INFORMATION

THIS SECTION IS TO BE COMPLETED BY THE PLAN MEMBER. **IF THERE ARE MORE THAN FOUR DEPENDENTS, PLEASE ATTACH A SEPARATE LIST. PLEASE PRINT CLEARLY, IN INK.**

SPOUSE INFORMATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

GENDER: MALE ☐ FEMALE ☐ DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____

WHAT GROUP BENEFITS COVERAGE DOES YOUR SPOUSE HAVE THROUGH THEIR EMPLOYER?

HEALTH CARE	SINGLE ☐	FAMILY ☐	WAIVED ☐	NONE ☐
DENTAL CARE	SINGLE ☐	FAMILY ☐	WAIVED ☐	NONE ☐
VISION CARE	SINGLE ☐	FAMILY ☐	WAIVED ☐	NONE ☐

WHERE APPLICABLE, BENEFIT PAYMENTS WILL BE COORDINATED BETWEEN THIS PLAN AND YOUR SPOUSE'S PLAN.

DEPENDENT INFORMATION			DATE OF BIRTH MONTH/DAY/YEAR	GENDER	FULL-TIME STUDENT	DISABLED DEPENDENT
LAST NAME	FIRST NAME	MIDDLE INITIAL		M ☐ F ☐		
LAST NAME	FIRST NAME	MIDDLE INITIAL		M ☐ F ☐		
LAST NAME	FIRST NAME	MIDDLE INITIAL		M ☐ F ☐		
LAST NAME	FIRST NAME	MIDDLE INITIAL		M ☐ F ☐		

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5. REFUSAL OF BENEFITS

This section is to be completed by the plan member.

NOTE: HEALTH AND/OR DENTAL COVERAGE CAN ONLY BE REFUSED IF YOU AND/OR YOUR DEPENDENTS ARE COVERED BY DUPLICATE GROUP BENEFITS THROUGH YOUR SPOUSE'S EMPLOYER.

I UNDERSTAND THE PLAN OF GROUP BENEFITS OFFERED TO ME, BUT I **DECLINE** TO PARTICIPATE IN:

HEALTHCARE FOR	MYSELF AND MY DEPENDENTS	☐	MY DEPENDENTS ONLY	☐
DENTALCARE FOR	MYSELF AND MY DEPENDENTS	☐	MY DEPENDENTS ONLY	☐

SPOUSAL INSURER'S NAME: _____ PLAN NUMBER: _____

IF YOU LOSE SPOUSAL COVERAGE YOU MUST APPLY FOR COVERAGE WITHIN 31 DAYS OF LOSS OF SUCH COVERAGE. PLEASE SEE YOUR PLAN ADMINISTRATOR FOR DETAILS.

6. PRIVACY

This section explains CPAIPW's commitment to privacy.

PROTECTING YOUR PERSONAL INFORMATION

AT CPA INSURANCE PLANS WEST, WE RECOGNIZE AND RESPECT THE IMPORTANCE OF PRIVACY. WHEN YOU APPLY FOR COVERAGE, WE ESTABLISH A CONFIDENTIAL FILE THAT CONTAINS YOUR PERSONAL INFORMATION. THIS FILE IS KEPT IN THE OFFICE OF CPA INSURANCE PLANS WEST OR THE OFFICES OF AN ORGANIZATION AUTHORIZED BY CPA INSURANCE PLANS WEST. WE ARE COMMITTED TO MEETING OR EXCEEDING THE PRIVACY STANDARD ESTABLISHED BY FEDERAL AND PROVINCIAL LEGISLATIONS AND INDUSTRY BODIES.

THE EMPLOYEES OF CPA INSURANCE PLANS WEST PLAY AN IMPORTANT ROLE IN PROTECTING PERSONAL INFORMATION. OUR EMPLOYEES ARE REQUIRED TO ADHERE TO THIS POLICY AND TAKE ALL REASONABLE STEPS TO ENSURE THAT PERSONAL INFORMATION IS PROTECTED.

THE PERSONAL INFORMATION THAT IS COLLECTED IS USED TO ADMINISTER AN INDIVIDUAL'S PARTICIPATION IN THE PLAN AND TO PAY BENEFITS AS DEFINED BY THE PLAN.

IN ADMINISTERING AN INDIVIDUAL'S PARTICIPATION IN THE PLAN, PERSONAL INFORMATION MAY ALSO BE COLLECTED FROM, OR DISCLOSED TO, INSURANCE COMPANIES OR OTHER COMPANIES THAT INSURE THE BENEFITS OR PROVIDE ADMINISTRATION AND CLAIMS HANDLING SERVICES; LICENSED PHYSICIANS OR OTHER HEALTHCARE PROFESSIONALS OR INSTITUTIONS; AND GOVERNMENT OR REGULATORY AUTHORITIES.

WE ONLY KEEP PERSONAL INFORMATION FOR AS LONG AS IS NECESSARY FOR THE PURPOSE OUTLINED PREVIOUSLY IN THIS POLICY. WE ARE ALSO REQUIRED BY LAW TO MAINTAIN CERTAIN INFORMATION FOR SET PERIODS OF TIME. WE HAVE APPROPRIATE SAFEGUARDS IN PLACE TO PROTECT PERSONAL INFORMATION AND WHEN WE NO LONGER NEED THE INFORMATION, IT IS DESTROYED.

7. AUTHORIZATION & DECLARATIONS

This section must be signed and dated in INK by the plan member.

AUTHORIZATION AND DECLARATION

I HAVE READ AND UNDERSTAND AND AGREE WITH THE CONTENTS OF THE SECTION TITLED "PROTECTING YOUR PERSONAL INFORMATION".

I AUTHORIZE:

CPA INSURANCE PLANS WEST, INSURANCE COMPANIES OR REINSURANCE COMPANIES, HEALTHCARE PROVIDERS, ADMINISTRATORS OF GOVERNMENT BENEFITS OR OTHER BENEFIT PROGRAMS, OTHER ORGANIZATIONS OR SERVICE PROVIDERS WORKING WITH CPA INSURANCE PLANS WEST OR THE ABOVE TO EXCHANGE PERSONAL INFORMATION WHEN RELEVANT AND NECESSARY TO DETERMINE MY ELIGIBILITY FOR COVERAGE AND TO ADMINISTER THE PLAN.

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____ _____

PLAN MEMBER SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

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