

# CPA INSURANCE PLANS WEST MASTER GROUP COVERAGE APPLICATION



## Section A. Company Information

Company Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Primary Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Number of Eligible Staff: \_\_\_\_\_ Effective Date: \_\_\_\_\_

## Section B. Insurance Coverage Information

Group Term Life:	1 x Annual Salary <input type="checkbox"/>	2 x Annual Salary <input type="checkbox"/>	3 x Annual Salary <input type="checkbox"/>
Long Term Disability:	60% of monthly salary (benefit is non-taxable if the employee pays 100% of premium) <input type="checkbox"/>		
	75% of monthly salary (benefit is taxable if paid 100% by the employer) <input type="checkbox"/>		
Waiting Period:	i) Partners and proprietors who are CPA members		
	30 Days <input type="checkbox"/>	90 Days <input type="checkbox"/>	113 Days <input type="checkbox"/>
	ii) CPAs and non-CPA employees		
	113 Days <input type="checkbox"/>	180 Days <input type="checkbox"/>	
Dependent Life:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Accidental Death and Dismemberment:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Critical Illness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	if yes: \$10,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/>
Extended Healthcare:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Prescription Drugs:	80% <input type="checkbox"/>	100% <input type="checkbox"/>	
Vision:	\$350 <input type="checkbox"/>	\$200 <input type="checkbox"/>	No <input type="checkbox"/>
Dental Care:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Basic Services (3 or more participants)	<input type="checkbox"/>	80% <input type="checkbox"/> 100% <input type="checkbox"/>
	Major Restorative (3 or more participants)	<input type="checkbox"/>	
	Orthodontics (15 or more participants)	<input type="checkbox"/>	

## Section C. Authorization and Declaration

The applicant firm hereby applies to join the CPAIPW Benefits Plan as of the “Effective date” and agrees that the insurance, once in force, will be subject to the master contracts issued by the insurers. In addition, we understand that, once the application has been approved and the insurance is in force, we will be responsible for ensuring that the administrative requirements such as prompt enrollment and notification to CPAIPW of termination and salary changes are met and the participation levels are met.

\_\_\_\_\_  
Authorization Signature

\_\_\_\_\_  
Date