# CA Insurance Plans West

Coverage that counts.

CA Insurance Plans West
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## CAIPW GROUP BENEFIT PLAN
## Firm Application for Group Insurance

Firm Name: _____

Street: _____

City or Town: _____ Prov.: _____ Postal Code: _____

Telephone number: _____ Contact Person: _____

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Number of Eligible Individuals: _____ Effective date: _____

Note: All eligible individuals must participate. Please refer to the firm brochure.

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| **Group benefits applied for:** | **YES** | **NO** |
|---|---|---|
| Term Life | ☐ | ☐ |
| Dependent Life | ☐ | ☐ |
| Accidental Death & Dismemberment (AD&D) | ☐ | ☐ |
| Long Term Disability (LTD) | ☐ | ☐ |
| Extended Health Care (EHC) | ☐ | ☐ |
| Dental Plan | ☐ | ☐ |

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**Elected Schedules** (check one for each benefit)

1. Group Term Life ☐ 1 x annual salary ☐ 2 x annual salary ☐ 3 x annual salary
   *Note: If AD&D benefit is elected, amount will equal the amount of Term Life benefit.*

2. Long Term Disability ☐ 60% of monthly salary *(benefit is non-taxable)* ☐ 75% of month salary *(benefit is taxable)*

   Waiting Period:
   i) Partners and Proprietors who are members ☐ 30 days ☐ 90 days
   ii) Employees ☐ 120 days ☐ 180 days

   Optional COLA indexing to 10% ☐ YES ☐ NO

3. Extended Healthcare ☐ 80% (on drugs) ☐ 100%

4. Dental Care ☐ A. Basic Services (five or more participants)
   ☐ 80% ☐ 100%
   ☐ B. Major restorative (ten or more participants)
   ☐ C. Orthodontics (fifteen or more participants)

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The Applicant Firm hereby applies to join the Chartered Accountants Benefit 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 CAIPW of termination and salary changes are met and that participation levels are met.

Authorized Signature _____ Date Signed _____