CPAIPW BENEFIT PLAN - TRANSACTION CARD

EMPLOYEE/MEMBER - PLEASE COMPLETE ALL INFORMATION EXCEPT FOR SHADED AREAS.

LAST NAME

FIRST NAME INITIAL

MALE FEMALE DATE OF BIRTH MONTH DAY YEAR

BENEFICIARY DESIGNATION

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies):

Beneficiary's name(s)			Percent	Relationship to applicant
Surname	First Name	Initial		
Surname	First Name	Initial		

To be divided   As per the percentages indicated above or,   In equal shares to the survivor(s)

You may change this beneficiary designation at any time by notifying CPAIPW. If designating a beneficiary who is a minor or who lacks legal capacity, please complete declaration on reverse.

HAVE YOU EVER USED TOBACCO PRODUCTS? *IF YOU USED TOBACCO PRODUCTS BUT STOPPED GIVE DATE STOPPED*

YES NO

This information is collected for the purpose of enrolling you and your eligible dependents in the benefit programs provided by your employer. Additional information may be required. If you have any questions about the information collected or the questions asked, please refer to CPAIPW privacy policy.

EMPLOYER: PLEASE COMPLETE SHADED AREA

FIRST NO. CERT NO.

ACTION REQUESTED: ADD CHANGE DELETE

DATE OF EMPLOYMENT *(ADDS ONLY)*

EFFECTIVE DATE OF CHANGE/DELETE

WAGE: PER MONTH PER YEAR

COVERAGE: EHC SINGLE FAMILY; DENTAL SINGLE FAMILY; DEP LIFE

IF SPOUSAL EXEMPTION REQUESTED COMPLETE DECLARATION ON REVERSE

STATUS: CPA YES NO PARTNER EMPLOYEE CPA STUDENT

FOR CPAIPW USE ONLY

LIFE ADD LTD EHC DEN

I hereby apply for the benefits provided by the policy or policies issued to my employer/association and authorize any deduction from my pay any contributions required to be made by me.

I, the undersigned employee/member, hereby appoint the person stated as my beneficiary on my employer's/association's current and/or future insurance benefits and understand that I may, to the extent permitted by law, change my beneficiary at any time in the future.

		MO.	DAY	YR.
APPLICANT	X			
EMPLOYER / WITNESS				

For Family EHC/Dental coverage

Please complete the section below listing ALL ELIGIBLE DEPENDENTS (including spouse) (consult your booklet for a description of eligible dependents)

First Name	Initial	Surname	Relationship	Gender Male	Gender Female	Date of birth Mo.	Day	Yr.	If dependent is Age 21-25* check box	Disabled check box
									☐	☐
									☐	☐
									☐	☐
									☐	☐
									☐	☐

*Indicate the name of school/university being attended

Co-ordination of Benefits-complete only if family coverage has been selected

Does your **spouse** have coverage available under any other policy?

☐ No ☐ Yes, please indicate type of coverage

☐ Medical ☐ Single ☐ Family

☐ Dental ☐ Single ☐ Family

☐ Visioncare ☐ Single ☐ Family

APPLICATION FOR COMMON-LAW COVERAGE DECLARATION

I, the undersigned, hereby certify
that I have been living with ______________________________
since ______________________________ and representing him/her as my spouse and that I am in a position of loco parentis with children ______________________________ aged ______________________________,
respectively who have been living in my place of residence since ______________________________.
I further certify that these individuals are not insured under any group insurance plan and that I and/or my (common-law) spouse are solely responsible for them financially. I further certify that I do not have or wish to provide coverage to my legal spouse, if any.

Upon approval of this application by the health underwriter, I agree that notwithstanding the provisions in the group policy(ies) defining eligible dependents, the only persons to be insured for dependent coverage are those persons named above.

WITNESS	EMPLOYEE/MEMBER SIGNATURE
X	X
DATE	PLEASE PRINT NAME

PLEASE COMPLETE OTHER SIDE OF CARD

DECLARATION APPOINTING TRUSTEE *Complete only if Beneficiary is underage*

I do hereby appoint ______________________________ as Trustee to receive any amount due to any beneficiary under 18 years of age and declare the receipt of such Trustee shall be a good discharge to the insurer for the amount so paid.

And I do hereby authorize such Trustee, within his discretion, to expend all or any portion of such amount and/or the income therefrom for the maintenance or education of such minor.

Dated at ______________________________ this ________ day of ______________________________ 20________

X	X
Signature of witness	Signature of life insured

SPOUSAL EXEMPTION

If you do not wish to participate under the EHC and/or Dental because you have similar coverage with your spouse's plan, please complete the following.

I claim a spousal exemption under the EHC ☐ and/or Dental ☐. My spouse is currently insured through a plan underwriten by:

Insurance Company ▷

Employee /Member Signature	D	M	Y