



**Group Insurance Trust of the  
California Society of Certified Public Accountants  
SUBSCRIPTION AGREEMENT  
Effective January 1, 2017  
Revised 9/20/2017 v.7**

(Please type or print clearly and initial or sign in the spaces provided.)

This Subscription Agreement (“Subscription Agreement”) is made by and between the employer identified below and the Board of Trustees of the Group Insurance Trust (“Trust”) of the California Society of Certified Public Accountants (“CalCPA”). It is established and maintained under a Trust Agreement, amended and restated as of May 1, 1997 and as thereafter further amended from time to time (“Trust Agreement”). Certain capitalized terms used in this Subscription Agreement are defined in the Trust Agreement.

This Subscription Agreement contains information concerning the employer and its Eligible Persons who are Employees\* and who satisfy (1) CalCPA’s criteria for coverage under a particular plan and (2) the employer-imposed waiting period (“Eligible Employee(s)”). This information will be used by the Board of Trustees to establish the employer's eligibility to become a Participating Employer in the Trust. With the Board of Trustees' approval (which it may give or withhold in its sole and exclusive discretion), the employer will become a Participating Employer as of the effective date specified by the Board of Trustees in the spaces provided below. Coverage effective dates for each Eligible Person will be determined according to the terms of the Group Membership Enrollment Form applicable to such person and the Medical Plan Document and Disclosure Form or the terms of the applicable Policy, as appropriate. Any conflict between the terms of this Subscription Agreement and the Trust Agreement will be resolved in favor of the Trust Agreement.

**Note: It is important to understand the terms and conditions of the coverage(s) you select. As concerns coverage through the Medical Plan of the Group Insurance Trust of the California Society of Certified Public Accountants (“Medical Plan”), the Medical Plan brochure contains essential information regarding the various coverage and benefit options available under the Medical Plan. Please do not complete this Subscription Agreement before reading the Medical Plan summary. If you have any questions regarding the terms and conditions of any coverage(s), please call Banyan Administrators - Managers for the CalCPA Health Programs at 877-480-7923.**

It is the subscriber's responsibility to notify Banyan Administrators – Managers for the CalCPA Health Programs in the event there is any change in the information represented on this Subscription Agreement. Subscribers may be asked to provide proof of information represented on this Subscription Agreement from time to time. If the subscriber fails to do either of the above, or violates any other provisions of this Subscription Agreement or the Trust Agreement, Trust participation privileges may be revoked.

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\* As used in this Subscription Agreement, an Employee includes any proprietor, shareholder or partner of the employer as well as an employee in the usual parlance.

## New Group Application Guidelines

### Submission Deadline

- All forms must be received by Banyan Administrators no later than the fifth (5<sup>th</sup>) of the month for which coverage is being requested. If the fifth (5<sup>th</sup>) of the month falls on a weekend or a holiday, then the submission deadline is the first subsequent regular workday.

### In order to be Eligible, an employer must:

- Be an accounting firm in public practice or a firm offering general financial services.
- Be headquartered in the state of California.
- Have more than 50% of enrolled employees residing in California.

### Employee Participation Requirements

- Medical : At least 75% of eligible employees\* must enroll.
- Dental and Vision : 100% of eligible employees\* must enroll.
- Life and Long Term Disability: 100% of full-time employees must enroll.  
\* Valid waivers for group Kaiser or spousal group coverage are excluded from the count.

### Required Forms

- Signatures cannot be dated more than 59 days prior to the requested effective date.
- Each full-time employee must complete an enrollment form. Please be sure to complete all fields; while making sure to sign and initial as indicated.
  - Medical/Dental/Vision Enrollment Form for Employees (when enrolling in Medical, this form can be used for Dental and vision as well).
    - Complete enrollment forms must be received by the seventh (7th) day of the month prior to the coverage effective date (or next business day if the 7th falls on a weekend or holiday) in order to have ID cards issued by the coverage effective date.
    - Employees waiving coverage must complete the Coverage Declination section and attach a copy of their ID card.
    - Delta Dental and/or Vision Service Enrollment Form for Employees. (Dental and/or Vision only)
    - Employees waiving coverage must complete the Coverage Declination section and attach a copy of their ID card.
  - Group Life-LTD Employee Enrollment Form (For groups of 2-9 only. Contact Banyan for groups of 10 or more.)
  - COBRA : All former employees applying for COBRA coverage must complete the COBRA Information section on page 2 of the Medical/Dental/Vision Enrollment Form for Employees.
- Health Statements must be completed by:
  - Firms of 2-3 employees applying for Life and/or Long Term Disability coverage.
- All groups must submit a copy of their most recent DE-9 and DE-9c.
- For groups electing the PPO HRA medical plan, the Request for HealthEquity HRA Administration form must be completed.

Missing signatures and questions left unanswered can delay the processing of your application. If you do not understand a question, please call Banyan Administrators – Managers for the CalCPA Health Programs at 877-480-7923. Once all questions have been answered, please mail or fax the completed and signed documents to:

Banyan Administrators  
Managers for the CalCPA Health Programs  
1215 Manor Drive, Suite 200  
Mechanicsburg, PA 17055  
Phone: 877-480-7923  
Fax: 877-237-4519  
calcpahealth@fnrm.com

Note: This document was written to summarize the main requirements for new group applications. This is not a complete list of underwriting guidelines, and additional information may be required.

**EMPLOYER ELIGIBILITY**

To obtain and maintain eligibility as an employer, more than 50% of all of the employer's owners (i.e., principals, proprietors, partners, shareholders, or other owners) must be CPA Members of CalCPA, or Associate Members of CalCPA. All CalCPA Members must hold and maintain their CalCPA membership in good standing. For purposes of this Subscription Agreement, all employers deemed to be part of an affiliated group under Internal Revenue Code Sections 414(b), (c) or (m) are considered to be a single "employer." Employers may be asked to provide proof of compliance with membership requirements from time to time.

**EMPLOYER INFORMATION**

EmployerName: \_\_\_\_\_

FederalEmployerIdentificationNumber (FEIN) **REQUIRED:** \_\_\_\_\_

StreetAddress: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ County \_\_\_\_\_

Contact \_\_\_\_\_ Email \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Title \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Type of Organization:     Proprietorship     Partnership     Corporation     Other: \_\_\_\_\_

**CalCPA MEMBERSHIP**

Please list all firm owners (i.e., principals, proprietors, partners, shareholders, or other owners). For each owner please indicate whether they are a member of CalCPA and provide their CalCPA membership identification number. **(Please note: The CalCPA membership identification number is not the CPA license #. If you do not know the membership identification number, please call CalCPA membership services at 800-922-5272.)**

<u>Name(s)</u>	<u>CalCPA Member</u>	<u>CalCPA ID # (not CPA license #)</u>
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____

Initial \_\_\_\_\_

**WAITING PERIOD FOR NEWLY HIRED EMPLOYEES**

**Please indicate the desired waiting period preceding the start of coverage for newly hired employees (check one):**  
**(Note: The waiting period applies to all plans selected.)**

Coverage should begin on the first of the month following:  Date of hire  30 days  60 days

**MINIMUM NUMBER OF HOURS REQUIRED TO BE ELIGIBLE FOR BENEFITS**

The Group Insurance Trust requires that employees must be employed by the firm on a permanent basis, with wages subject to withholding that are reported on a W-2 form. Such employees are eligible to enroll in CalCPA Health if they are actively at work at least 20 hours per week. However, the employer may elect to offer benefits only to those employees working 30 or more hours per week. Please indicate the number of hours required to be eligible for benefits. Note: This election must apply to all members of the firm and if no election is made, the standard for plan coverage will be employees working a minimum of 20 hours.

**Select one:**

All Employees working a minimum of  20 hours (or)  30 hours per week are eligible to enroll.

**EMPLOYER CONTRIBUTION**

The employer must contribute a minimum of 50% of the cost of the Employees' medical premiums, and 100% of employee's dental, vision, life or long term disability premiums (does not include cost of dependent coverage). What percentage of the Employees' medical premium does the firm contribute?  50%  100%  Other \_\_\_\_\_%

**EMPLOYEE INFORMATION – CalCPA Health MEDICAL PLANS & ANTHEM BLUE CROSS (HMO)**

**Note: "Employee" includes any proprietor, shareholder or partner of the employer as well as an employee in the usual parlance.**

- (1) Total number of Employees, as of the date the employer executes this Subscription Agreement: \_\_\_\_\_
- (2) Number of Employees working less than 20 hours per week (or 30 if elected by Employer \_\_\_\_\_
- (3) Number of Employees covered by a group health plan sponsored by an employer or Medicare: \_\_\_\_\_
- (4) Number of Eligible Employees (subtract lines (2) and (3) from line (1)): \_\_\_\_\_
- (5) Number of Eligible Employees declining coverage for other reasons: \_\_\_\_\_
- (6) Number of Eligible Employees who will be covered (subtract lines (5) from line (4)): \_\_\_\_\_
- (7) Number of former Employees on COBRA or Cal-COBRA: \_\_\_\_\_
- (8) Name of current COBRA Administrator: \_\_\_\_\_

**Has your firm filed a DE-9 and DE-9C (Quarterly Contribution Return and Report of Wages) with the Employment Development Department (EDD)?**

- Yes. *Please provide a copy of your most recent DE-9 and DE-9C.*
- No, the firm has been newly established within the last 90 days. *Please provide 30 days of payroll.*
- No, the firm has been newly established within the last 30 days.
- No, I am the sole employee.

**If the total number of Eligible Employees listed in line (4) is less than 2 or greater than 50, did the employer have at least 2 but no more than 50 Eligible Employees on at least 50% of the employer's working days during the preceding calendar quarter or preceding calendar year?**  Yes  No

Initial \_\_\_\_\_

**EMPLOYEE INFORMATION – DENTAL PLANS and VISION PLAN**

- (1) Total number of Employees, as of the date the employer executes this Subscription Agreement: \_\_\_\_\_
- (2) Number of Employees working less than 20 hours per week (or 30 if elected by Employer): \_\_\_\_\_
- (3) Number of Eligible Employees (subtract line (2) from line (1)): \_\_\_\_\_
- (4) Number of Eligible Employees covered by a group Vision or Dental Plan sponsored by another employer: \_\_\_\_\_
- (5) Number of Eligible Employees who will be covered (subtract line (4) from line (3)): \_\_\_\_\_

**EMPLOYEE INFORMATION – GROUP LONG TERM DISABILITY & GROUP TERM LIFE**

- (1) Total number of Employees, as of the date the employer executes this Subscription Agreement: \_\_\_\_\_
- (2) Number of Employees working less than 30 hours per week: \_\_\_\_\_
- (3) Number of Eligible Employees (subtract line (2) from line (1)) \_\_\_\_\_
- (4) Number of Eligible Employees who will be covered (subtract line (4) from line (3)): \_\_\_\_\_

## **MEDICAL PLAN SELECTIONS**

On the following pages, please select the desired coverage(s) from one or more of the following plans: (1) CalCPA Health Medical Plans; (2) Anthem Blue Cross HMO Plans; (3) Vision Service Plan; (4) Dental Plans; and/or (5) Group Long-Term Disability and Group Term Life.

### **Medical Plan Underwriting Guidelines**

Subject to the provisions of the Medical Plan Document and Disclosure Form relating to enrollment and late enrollment: (1) each Employee of the employer is an Eligible Person; (2) if the firm is a proprietorship or partnership, each principal or partner of the firm is an Eligible Person; (3) each spouse and family member, as such terms are respectively defined in the Medical Plan Document and Disclosure Form, is an Eligible Person. Any conflict between the terms of this Subscription Agreement and the Medical Plan Document and Disclosure Form will be resolved in favor of the Medical Plan Document and Disclosure Form.

### **Contribution Requirements**

The employer must contribute a minimum of 50% of the cost of the Employees' medical premiums, and 100% of employee's dental, vision, life or long term disability premiums (does not include cost of dependent coverage). Payroll deduction withholding is required to collect Employee contributions used to pay premium costs.

### **Employees**

Only active, regular, full-time (working at least 20 hours per week, or 30 if elected by the Employer) Employees and self-employed persons (such as proprietors and partners) are considered Eligible Employees for purposes of health coverage provided through the Trust.

### **Employees covered under other group medical plans**

Employees who waive coverage on the grounds that they have other group medical coverage shall not be counted as Eligible Employees.

### **1099 Recipients**

Independent contractors whose annual payments from the employer are reported on IRS form 1099 are not eligible to participate.

### **Spouses**

If a husband and wife are employed by the same employer, they may both be covered as Employees. Eligible children may be considered Dependents of either one or both of the Employee parents.

## PLANSELECTIONS

Please check here if you are a group currently enrolled with CalCPA Health. If so, please provide your client code below.

\_\_\_\_\_

### **1: MEDICAL PLAN SELECTION**

PPO and HMO Network Plans:

- |  |   |
|--|---|
| <input type="checkbox"/> PPO 10/0/10%          | <input type="checkbox"/> PPO HRA 45/1000/10%  |
| <input type="checkbox"/> PPO 20/500/25%        | <input type="checkbox"/> PPO HSA 1300/50%     |
| <input type="checkbox"/> PPO 25/500/30%        | <input type="checkbox"/> PPO HSA 1700/30%/RxC |
| <input type="checkbox"/> PPO 25/500/30% RxV    | <input type="checkbox"/> PPO HSA 2600/20%/RxC |
| <input type="checkbox"/> PPO 35/1000/40%       | <input type="checkbox"/> PPO HSA 3500/30%/RxC |
| <input type="checkbox"/> PPO 40/1500/40%       | <input type="checkbox"/> PPO HSA 4500/20%/RxC |
| <input type="checkbox"/> PPO 40/1500/40% RxV   | <input type="checkbox"/> PPO HSA 5500/0%/RxC  |
| <input type="checkbox"/> PPO 45/1500/50%       | <input type="checkbox"/> HMO 10/0%            |
| <input type="checkbox"/> PPO 45/5000/10% Saver | <input type="checkbox"/> HMO 35/20%           |

Select PPO and Select HMO Network Plans:

- |   |  |
|---|--|
| <input type="checkbox"/> Select PPO 10/0/10%          | <input type="checkbox"/> Select PPO HRA 45/1000/10%  |
| <input type="checkbox"/> Select PPO 20/500/25%        | <input type="checkbox"/> Select PPO HSA 1300/50%     |
| <input type="checkbox"/> Select PPO 25/500/30%        | <input type="checkbox"/> Select PPO HSA 1700/30%/RxC |
| <input type="checkbox"/> Select PPO 25/500/30% RxV    | <input type="checkbox"/> Select PPO HSA 2600/20%/RxC |
| <input type="checkbox"/> Select PPO 35/1000/40%       | <input type="checkbox"/> Select PPO HSA 3500/30%/RxC |
| <input type="checkbox"/> Select PPO 40/1500/40%       | <input type="checkbox"/> Select PPO HSA 4500/20%/RxC |
| <input type="checkbox"/> Select PPO 40/1500/40% RxV   | <input type="checkbox"/> Select PPO HSA 5500/0%/RxC  |
| <input type="checkbox"/> Select PPO 45/1500/50%       | <input type="checkbox"/> Select HMO 10/0%            |
| <input type="checkbox"/> Select PPO 45/5000/10% Saver | <input type="checkbox"/> Select HMO 35/20%           |

**Were Employees of the employer covered by any other group health plan during the last 60 days?**

No

Yes - Name of Provider (Carrier, HMO, MEWA, etc.): \_\_\_\_\_

Policy #: \_\_\_\_\_

Date of Termination: \_\_\_\_\_

### **2. VISION PLAN SELECTION**

Please select the provider network you wish to use:

- Signature (broad) Network     Choice (narrow) Network

Please select the plan option that you wish to offer:

- Enhanced (glasses/contacts every 12 months)     Standard (glasses/contacts every 24 months)
- Premier Plan (glasses/contacts every 12 months)

### **3. DENTAL PLAN SELECTION**

Delta Dental

Have any of the firm's owners become a new member of CalCPA within the last 60 days? No \_\_\_\_\_ Yes \_\_\_\_\_

If Yes - Name: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** The Dental and Vision plans require participation of 100% of all Eligible Employees. Full time employees must have other group coverage to be a valid waiver

### **4. GROUP LONG-TERM DISABILITY AND GROUP TERM LIFE**

- |   |  |
|---|--|
| <input type="checkbox"/> Group Long-Term Disability<br>(Choose one) : | <input type="checkbox"/> Option 1 (60% of the monthly rate of basic earnings less other benefits up to \$6,000 per month)  |
|   | <input type="checkbox"/> Option 2 (60% of the monthly rate of basic earnings less other benefits up to \$10,000 per month) |
| <input type="checkbox"/> Group Term Life—Choose one:                  | <input type="checkbox"/> Option 1 (one times annual earnings up to \$50,000)   |
|   | <input type="checkbox"/> Option 2 (two times annual earnings up to \$100,000)  |

**NOTE:** Group Long-Term Disability and Group Term Life requires 100% participation of all active, regular, full-time (working at least 30 hours per week) Employees.

**GENERAL PROVISIONS**

1. The employer agrees, and, as a condition of being entitled to receive any benefit provided through the Trust, the Medical Plan, or any Policy, each Eligible Person or any other person claiming such benefits must agree (the employer and each Eligible Person and such other person being hereafter referred to collectively in this paragraph 1 as the "Employer") that:
  - (a) CalCPA, the committee, the administrator, the Board of Trustees, the Trust, the Medical Plan and the shareholders, directors, trustees, officers, employees and agents of each (hereafter referred to collectively in this paragraph 1 as "CalCPA") shall have no responsibility or liability with respect to the provision or quality of any service provided by any medical or other service provider (including, without limitation, any malpractice liability); and
  - (b) all claims and controversies ("Claims") that the Employer may have against CalCPA, and that CalCPA may have against the Employer, which claims arise under or relate to this Subscription Agreement, the Medical Plan Document and Disclosure Form (if applicable), or the Trust Agreement, shall be resolved by binding arbitration in accordance with the Commercial Arbitration Procedures of the American Arbitration Association, except as otherwise provided herein. Each party shall share equally the fees and costs of the arbitrator. The Employer and CalCPA agree that the aggrieved party must give written notice to the other party within 120 days of the date the aggrieved party first has knowledge of the event giving rise to the claim; otherwise the claim shall be void and deemed waived notwithstanding any Federal or State statute of limitations. Either party may bring an action in a court of competent jurisdiction to compel arbitration hereunder and to enforce an arbitration award. The Employer and CalCPA agree that, except as otherwise provided in this paragraph 1, neither of them shall initiate nor prosecute any lawsuit or other proceeding in any way related to a claim covered by this Subscription Agreement. The provisions of this paragraph 1 do not apply to any claim subject to arbitration under the Medical Plan Document and Disclosure Form.
2. The employer agrees to enroll all Eligible Persons to be covered under the Medical Plan Document and Disclosure Form or any Policy provided under the Trust Agreement, as appropriate, on enrollment forms provided by the Trust's sales agent ("Agent"). The enrollment forms should be sent to the Agent at the address indicated at the end of this Subscription Agreement.
3. The employer agrees to complete and submit enrollment forms for any new Eligible Person who is to be covered under the Medical Plan Document and Disclosure Form or any Policy provided under the Trust Agreement, as appropriate, to the Agent within 31 days after such person achieves Eligible Employee status. Coverage for such persons may be delayed or denied if enrollment forms are not submitted in a timely manner. In addition, the employer agrees to timely update the Agent regarding any changes (including without limitation terminations and changes in Dependents' status) in the information supplied on this Subscription Agreement or, if known to the employer, on any enrollment forms.
4. The employer agrees to make contributions to the Trust in the amount, at the time or times, and in the manner specified from time to time by the Board of Trustees. **NOTE: Any failure by the employer to pay contributions in a timely manner may result in an irrevocable lapse of coverage, without any prior notice of delinquency.**
5. The employer agrees to be bound by the terms of the Trust Agreement to the extent applicable to the employer and its Eligible Persons and to abide by all operating rules and regulations established from time to time by the Board of Trustees.
6. The employer acknowledges that the Trust was created to provide for the provision of group coverage as a matter of convenience and accommodation to the employer and its Eligible Persons and, in consideration therefor, agrees to indemnify and hold harmless CalCPA, the Board of Trustees, the Agent, the service administrator, and any fiduciary of the Trust against and from all claims, demands, losses, liabilities, and expenses (including reasonable attorneys' fees and costs) arising out of the negligence or willful misconduct or material breach of this Subscription Agreement by the employer.

Dated: \_\_\_\_\_

Full Name of Employer: \_\_\_\_\_

Signed By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Initial \_\_\_\_\_