Group Insurance Trust of the

California Society of Certified Public Accountants

SUBSCRIPTION AGREEMENT

Effective January 1, 2017

Revised 10/26/2016 v.6

(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.

* 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.

CalCPA Health

New Group Application Guidelines

Submission Deadline

- All forms must be received by Banyan Administrators no later than the fifth (5th) of the month for which coverage is being requested. If the fifth (5th) 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.
    - 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.

Initial_____

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

Employer Name: _____

Federal Employer Identification Number (FEIN) REQUIRED: _____

Street Address: _____

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.**)

Name(s)	**CalCPA Member**	**CalCPA ID #** (not CPA license #)
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____
_____	Yes No	_____

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

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)): _____

Initial _____

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.

PLAN SELECTIONS

1. MEDICAL PLAN SELECTION

PPO and HMO Network Plans:

- ☐ PPO 10/250/10%
- ☐ PPO 15/500/20%
- ☐ PPO 25/500/30%
- ☐ PPO 25/500/30% RxV
- ☐ PPO 35/1000/40%
- ☐ PPO 40/1500/40%
- ☐ PPO 40/1500/40% RxV
- ☐ PPO 45/1500/50%
- ☐ PPO 45/5000/10% Saver
- ☐ PPO HRA 45/1000/10%
- ☐ PPO HSA 1700/30%RxC
- ☐ PPO HSA 2600/20%/RxC
- ☐ PPO HSA 3500/30%/RxC
- ☐ PPO HSA 4500/20%/RxC
- ☐ PPO HSA 5500/0%/RxC
- ☐ HMO 10/0%
- ☐ HMO 35/20%

Select PPO and Select HMO Network Plans:

- ☐ Select PPO 10/250/10%
- ☐ Select PPO 15/500/20%
- ☐ Select PPO 25/500/30%
- ☐ Select PPO 25/500/30% RxV
- ☐ Select PPO 35/1000/40%
- ☐ Select PPO 40/1500/40%
- ☐ Select PPO 40/1500/40% RxV
- ☐ Select PPO 45/1500/50%
- ☐ Select PPO 45/5000/10% Saver
- ☐ Select PPO HRA 45/1000/10%
- ☐ Select PPO HSA 1700/30%/RxC
- ☐ Select PPO HSA 2600/20%/RxC
- ☐ Select PPO HSA 3500/30%/RxC
- ☐ Select PPO HSA 4500/20%/RxC
- ☐ Select PPO HSA 5500/0%/RxC
- ☐ Select HMO 10/0%
- ☐ 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

☐ Group Long-Term Disability–Choose one:
- ☐ Option 1 (60% of the monthly rate of basic earnings less other benefits up to $6,000 per month)
- ☐ Option 2 (60% of the monthly rate of basic earnings less other benefits up to $10,000 per month)

☐ Group Term Life–Choose one:
- ☐ Option 1 (one times annual earnings up to $50,000)
- ☐ 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.

Employee Enrollment Form

To be completed by each employee becoming a member of a medical, dental or vision plan, applying for COBRA coverage, or waiving coverage.

Type of Enrollment:

New Enrollment **Re-Hire** **Re-Enrollment** **Late Enrollment** **COBRA**

Firm Name:________________________ **Client Code:** _________________ six digit number

Date of Hire/Rehire (mm/dd/yy) : __________

Requested Effective Date: ______________

Number of hours worked per week:

Personal Information - *Please complete requested information*

Last Name (Print)	First	MI

Home Phone/Cell Phone	Business Phone	Email

Street Address (not PO Box)	City	State	Zip	Date of Birth

Elections (REQUIRED INFORMATION)

Employee and Family information - Please Note: Under the Medicare, Medicaid and State Children's Health Insurance Plan Extension Act of 2007, Social Security numbers for ***ALL*** family members are required. Please list yourself and all eligible family members to be enrolled by filling out the requested information. Check the Totally Disabled Yes box only if the individual's condition prohibits him/her from working or performing daily activities.

Medical Plan Selected: __________________ **(Please indicate plan name)** | **Dental** | **Vision**

Relationship	Last Name	First Name	MI	SSN	DOB	Age	Gender	Full-Time Student	Totally Disabled	PMG/IPA Number (if applicable) *	Cover/ Waive (Medical)	Cover/ Waive (Dental)	Cover/ Waive (Vision)
Self							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Dependents													
Spouse							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Domestic Partner							□ M □ F		□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive
Child							□ M □ F	□ Y □ N	□ Y □ N		□ Cover □ Waive	□ Cover □ Waive	□ Cover □ Waive

***If medical selection is the HMO Advantage 100 or HMO Value 80, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA): PMG or IPA Medical Office Number. Please refer to Anthem Blue Cross Provider Directory or www.anthem.com for PMG or IPA Number.**

Other Medical Coverage for Each Enrolling Employee and Dependents: ***All questions must be answered.***

Do any persons on this application intend to continue other Group coverage if this application is accepted? □ Y □ N

If Yes, Name of person_________________________ Insurance Co._______________________ Policy # __________________

Would you prefer to receive vital documentation regarding ProtectPlus in a language other than English? □ Y □ N If Yes, what language: _______________________

Please return completed form via Fax: 877-237-4519 or Email: CalCPAHealth@fnrm.com

Mail: Banyan Administrators 1215 Manor Drive Ste 200 Mechanicsburg, PA 17055

CalCPA ProtectPlus

Employee Enrollment Form

Coverage Declination - *Please complete if you are declining or refusing any coverage for yourself and/or eligible family members*

Medical Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Dental Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Vision Plan Coverage - I decline coverage for: ☐ Myself ☐ Spouse ☐ Children

Reason for Declining Health plan Coverage:

☐ Employee covered as a dependent under spouse's employer medical plan Carrier Name and ID#_____(Please include copy of current ID card)

☐ Employee covered by Champus or Champva (Please include copy of current ID card)

☐ Employee/spouse covered by Medicare (Please include copy of current ID card)

☐ Employee enrolled in a group HMO Carrier Name_____(Please include copy of current ID card)

☐ Employee covered by an individual policy

☐ Other (explain) _____

I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

By declining this group medical coverage (unless employee and/or dependent have group medical coverage elsewhere), I acknowledge that my dependents and I may have to wait 12 months from the date of this application to be enrolled in this group medical plan and that pre-existing conditions will not be covered for 6 months.

Notwithstanding the foregoing, if you are declining enrollment for yourself and dependents because of other health insurance coverage, you may in the future be able to enroll yourself or dependents in this plan, provided you request enrollment within 31 days after other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Please sign if you are declining coverage for yourself and/or dependents. *Your employer will keep a copy of this declination on file*.

Employee Signature:_____Date:_____ Employer:_____Group Number _____

COBRA Information - *To be completed by employer and initialed by applicant when applying for COBRA coverage*

For an Employee: Is Qualifying Event ☐ Voluntary ☐ Involuntary

☐ Termination ☐ Reduction in employee's work hours ☐ Benefits terminated or reduced within one year before or after a retired employee's employer filed for bankruptcy under Chapter 11

For a Family Member:

☐ Death of Employee ☐ Divorce or legal separation from employee ☐ Loss of dependent child eligibility status ☐ Employee becomes entitled to Medicare

☐ Benefits terminated or reduced within one year before or after a retired employee's employer filed for bankruptcy under Chapter 11

Other : If enrolled from a prior carrier's COBRA coverage, please indicate the qualifying event, applicable dates and stipulated information below:

Date of Qualifying Event_____Date of Loss of Coverage_____Date When Continued Coverage Ends_____Date Notice Given _____

Applicant's Initials_____Group Policyholder Representative Signature and Title_____Telephone Number _____

Definitions - *Please Read*

The term "Trust" means the Group insurance Trust of the California Society of Certified Public Accountants. The term "Trust" also includes the Board of Trustees of the Trust, the Service Administrator and their respective employees, officers and agents. The term "Service Administrator" means BC Life and Health Insurance Company or any replacement appointed by the Board of Trustees. The term "Member" means an enrolled employee, spouse, domestic partner, or dependent.

Effective Date - *Please Read*

The effective date of coverage is based on your firm's established waiting period and is subject to approval by the Service Administrator

Non-Participating Provider - *Please read and initial*

I understand that I am responsible for a greater portion of my medical costs when I use a non-participating hospital, physician, pharmacy or other provider.

Applicant's Initial _____

CalCPA ProtectPlus

Employee Enrollment Form

Authorization to Obtain or Release Medical Information - *Please read, sign and date*

The Trust and the Service Administrator are authorized to obtain and release medical information in compliance with the Medical information Act. Section 56 et. Seq of the California Civil Code and the Insurance Information and Privacy Protection Act, Section 791 et seq. of the California Insurance Code.

I hereby authorize any physician, healthcare practitioner, hospital, clinic or other medical or medically related facility to furnish to an agent, designee, or representative of the Service Administrator or of the Trust any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.

I also authorize the Trust and the Service Administrator and their affiliates, or their agents, designees or representatives to disclose to a hospital or healthcare service plan, self-insured plan, or insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

This authorization also permits disclosure of any such medical information to my employer, the Trust or Service Administrator for purposes of utilization review or financial audit.

This authorization shall become effective immediately and shall remain in effect as long as necessary to enable the Service Administrator and its affiliates to process claims or conduct a utilization review or financial audit. I understand that I have a right to receive a copy of this authorization.

Employee Signature:_____ Date: _____

Applicant must sign and date this medical information authorization

Deduction Authorization - *Please read and initial*

If applicable, I authorize my employer to deduct the required contribution from my wages.

Initial: _____

Arbitration Agreement - *Please read and initial*

I agree that any dispute between myself (and/or any family member) and the Trust shall be resolved by binding arbitration, as is more completely set forth in the applicable ProtectPlus Plan Document, if the amount in dispute exceeds the jurisdictional limit of the Small Claims court, and not any lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Under this coverage, both the member and the Trust are giving up the right to have any dispute decided in a court of law before a jury.

Initial: _____

Subrogation for Injury Recoveries - *Please read and initial*

I agree that if I, or a member of my family, is injured through the act of omission of another person (a third party), the Trust shall be subrogated to all rights of me and my family members to recover against such third party as a result of such injury to the extent that the Trust pays benefits under the ProtectPlus Plan for covered services or otherwise related to such injury. At the request of the Trust, I hereby agree to execute a writing (i) providing for the reimbursement of the Trust to the extent of benefits provided immediately upon collection of damages for such injury by me or a family member, whether by action at law settlement or otherwise; and (ii) providing the Trust with a lien to the extent of benefits provided under the plan upon the claim against the third party. The lien may be perfected by the Trust and/or filed with the third party or the court.

Initial: _____

Please Note:

Proof of prior coverage may be required by Anthem Blue Cross to waive the six-month pre-existing condition clause as of applicant's enrollment date. Acceptable forms of proof include a HIPAA coverage certificate, copy of I.D. Card, copy of payroll stub showing medical coverage deduction, or copy of most recent medical premium bill.

Signature of Understanding - *Please read, sign and date*

I have read and understand the provisions outlined in this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied an/or the policy being rescinded. I understand that I am entitled to a copy of this signed authorization for my files.

Signature of Employee:_____ Signature of Employee's Spouse/Domestic Partner (if applying for coverage) _____

Date:_____ Date: _____

Signature of Firm Administrator: _____

Date: _____

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 _____