

# CPA ProtectPlus

## GROUP TERM LIFE/LTD ENROLLMENT FORM



PLEASE SEE PAGE 2 FOR IMPORTANT INFORMATION REGARDING THIS FORM

**TO BE COMPLETED BY THE EMPLOYEE**

Last Name: \_\_\_\_\_ M.I. \_\_\_\_\_ First Name \_\_\_\_\_ LIFE  YES  NO  
 LTD  YES  NO

SOCIAL SECURITY #	GENDER: <input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE: M/D/Y
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EMPLOYEE HOME ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**BENEFICIARY DESIGNATION**—Please refer to page 2 for important information regarding beneficiary designation. If extra space is necessary, please use the space on Page 2 titled “Beneficiary Designation Form.”

PRIMARY:	D.O.B.	FULL NAME	ADDRESS	SSN	RELATIONSHIP
SECONDARY:	D.O.B.	FULL NAME	ADDRESS	SSN	RELATIONSHIP

\_\_\_\_ I hereby apply for the coverages I have indicated above on behalf of myself and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Lincoln Financial and my Group Plan.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYER**

EMPLOYER NAME \_\_\_\_\_ CLIENT CODE (IF APPLICABLE) \_\_\_\_\_

EMPLOYEE HIRE DATE \_\_\_\_\_ REQUESTED EFFECTIVE DATE OF COVERAGE \_\_\_\_\_

**COVERAGE:** Indicate type of coverage below. You may only elect coverages reflected in your contract. To elect coverage check the box marked “Option 1” or “Option 2.”

*BASIC LIFE <input type="checkbox"/> OPTION 1 <input type="checkbox"/> OPTION 2 Amount _____	**LONG TERM DISABILITY <input type="checkbox"/> OPTION 1 <input type="checkbox"/> OPTION 2 Amount _____
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\*\*\*Earnings \$ \_\_\_\_\_  Annual  Monthly  Weekly  Hourly

Please complete and return to: Banyan Administrators, LLC  
1215 Manor Drive, Suite 200  
Mechanicsburg, PA 17055 Phone: (877) 480-7923  
Fax: (877) 237-4519  
cpaprotectplus@banyan-llc.com

For firms enrolling 2-3 employees - all applicants must fill out a personal health statement (available at [cpaprotectplus.com](http://cpaprotectplus.com))

Instructions:

- Have the employee thoroughly complete the top portion of the enrollment form (Page 1).
- For Life coverage, the employee must designate a beneficiary. Information on beneficiary designations is included below.
- Employer Name—If insurance plan covers multiple entities, always use the name of the entity to which the insurance contract was issued.
- Employee Hire Date—For new employees use the employee’s date of hire. For current employees who move into an eligible class, be sure to use the date on which the employee became eligible—not the employee hire date.
- Requested Effective Date of Coverage—Date that the employee’s coverage becomes effective under the group plan. For original and new employees this is the day after the new employee completes the designated Eligibility Waiting Period (established by the firm on their Subscription Agreement).
- Coverage—Check the “Y” or “N” boxes for coverages that are included in your policy and for which the employee is eligible.
- Earnings—The gross amount the employee earns. Be sure to indicate if the salary is Annual, Monthly, Weekly, or Hourly. Note: Changes in Earnings must be reported to Banyan Administrators.

**NAMING YOUR BENEFICIARY**—It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary *and* secondary beneficiary. When naming your beneficiary(ies) please indicate their full name, date of birth, address, social security number, relationship, and the percentage that should be allocated to that individual. If the beneficiary is not related either by blood or marriage insert the words “Not Related.” If you need assistance, contact your company representative or your own legal counsel. If you name more than one beneficiary with unequal shares, please show the percentage of insurance to be paid to each beneficiary in the space below. If the following space does not meet your needs, please attach a letter that clearly states how you want the benefits to be paid.

\*Basic Life Option 1 is defined as coverage of one times an employee’s annual earnings up to \$50,000. Option 2 is defined as coverage of two times and employee’s annual earnings up to \$100,000. Benefit levels will reduce by 35% at ages 65, 70, and 75 and by an additional 25% at ages 80, 85, 90, and 95.

\*\*Long Term Disability Option 1 is defined as a monthly benefit of 60% of the Eligible Employee’s monthly rate of basic earnings up to a maximum of \$6,000 per month. Option 2 is defined as a monthly benefit of 60% of the Eligible Employee’s monthly rate of basic earnings up to a maximum of \$10,000 per month.

\*\*\*Earnings Definition: Monthly Rate of Basic Earnings means the Eligible Employee’s regular monthly rate of pay including bonuses and commissions average over the prior 12 months, excluding overtime, and any additional compensation; not to exceed the pay reported by the Employer.

BENEFICIARY DESIGNATION FORM - Please use this space if you need extra room to designate beneficiaries.					
PRIMARY:					
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	% _____
SECONDARY:					
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	% _____