



**Group Insurance Trust of the  
California Society of Certified Public Accountants**  
**SUBSCRIPTION AGREEMENT**

**Effective November 1, 2009**

**Revised 11/19/2009**

(Please type or print clearly and initial or sign in the space 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 Seabury & Smith Insurance Program Management at 1-800-824-1154.**

**INSTRUCTIONS FOR COMPLETION**

Please make sure you read and complete each question. Questions left unanswered can delay the processing of this Subscription Agreement and your application. If you do not understand a question, please call Seabury & Smith Insurance Program Management at 1-800-824-1154. Once all questions have been answered, please mail or fax the completed and signed Subscription Agreement to:

**Seabury & Smith Insurance Program Management  
CalCPA Account  
One California Street  
San Francisco, CA 94111  
Fax: 1 800 682-8787**

It is the subscriber's responsibility to notify Seabury & Smith Insurance Program Management 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.

Initial \_\_\_\_\_

**EMPLOYER INFORMATION**

Employer Name: \_\_\_\_\_

Federal Employer Identification Number (FEIN): \_\_\_\_\_

Street Address: \_\_\_\_\_

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

Contact \_\_\_\_\_ Title \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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

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

**CalCPA MEMBERSHIP**

Please list all CPAs in the firm. For each CPA please indicate whether they are owners/partners 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 1 800 922-5272. )**

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

**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 CPAs, or Associate Members of CalCPA, and all CPA-owners must be members of CalCPA 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.

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  
Or, following the completion of a waiting period of:  one month     two months     three months  
 other \_\_\_\_\_ (not to exceed 6 months)

**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 ProtectPlus 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.

**EMPLOYEE INFORMATION – MEDICAL PLAN & CALIFORNIA CARE (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) and/or who have not satisfied employer-imposed waiting period: \_\_\_\_\_
- (3) Number of Eligible Employees (subtract line (2) from line (1)): \_\_\_\_\_
- (4) Number of Eligible Employees covered by a group health plan sponsored by another employer: \_\_\_\_\_
- (5) Number of Eligible Employees declining coverage for other reasons: \_\_\_\_\_
- (6) Number of Eligible Employees who will be covered (subtract the sum of lines (4) and (5) from line (3)): \_\_\_\_\_
- (7) Number of Eligible Employees listed in line (6) with Dependents: \_\_\_\_\_
- (8) Number of former Employees on COBRA or Cal-COBRA: \_\_\_\_\_

If the total number of Eligible Employees listed in line (3) 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

**(Note: In circumstances where a spouse is the only full-time employee of a licensed member, the firm may be required to provide a copy of the spouse’s most recent W-2 form to verify the employment relationship.)**

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) and/or who have not satisfied the employer-imposed waiting period: \_\_\_\_\_
- (3) Number of Eligible Employees (subtract line (2) from line (1)): \_\_\_\_\_
- (4) Number of Eligible Employees covered by a group health 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 and/or who have not satisfied the employer-imposed waiting period:  
\_\_\_\_\_
- (3) Number of Eligible Employees (subtract line (2) from line (1)): \_\_\_\_\_
- (4) Number of Eligible Employees covered by a group health plan sponsored by another employer: \_\_\_\_\_
- (5) 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) ProtectPlus 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' premiums. Payroll deduction withholding is required to collect Employee contributions used to pay premium costs.

### **Participation Requirements**

#### *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. Employers having three or fewer Eligible Employees, and employers paying 100% of the premium, must enroll all of such persons. All other employers must enroll at least 75% of their Eligible Employees. Employers may be asked to provide proof of compliance with these coverage requirements from time to time.

#### *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.

#### *Dependents*

At least 50% of the eligible Dependents must enroll. However, if the employer is paying 100% of the Dependent premium cost, then all of the eligible Dependents must enroll. Dependents who waive coverage on the grounds that they have other group medical coverage shall not be counted as eligible Dependents.

#### *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.

Initial \_\_\_\_\_



**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 \_\_\_\_\_

Please mail or fax the completed and signed Subscription Agreement, all Group Enrollment Forms and any other requested documentation to:

Seabury & Smith Insurance Program  
Management  
CalCPA Account  
One California Street  
San Francisco, CA 94111

OR

Fax number: 1-800-682-8787

*(Please do not write below this line)*

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***TO BE COMPLETED BY SEABURY & SMITH INSURANCE PROGRAM MANAGEMENT.***  
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**FOR OFFICE USE ONLY**

Date Received: \_\_\_\_\_

**ACCEPTANCE**

The above-named employer is hereby accepted as of \_\_\_\_\_ as a Participating Employer under the Trust.

For the Board of Trustees of the Trust:

Seabury & Smith Insurance Program Management

Signature: \_\_\_\_\_

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

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