



Consumer Purchasing Alliance

Insurance Application Submittal

Date:

Member ID:

Member's Name:

Agent Code:

Agent Name:

Please review checklist before you send the Enrollment Application

- Applicant must complete **Section I** (Enrollment Form).
- Agent must complete first part of **Section II** and sign (Billing Form).
- Applicant must complete the rest of **Section II** (Billing Form).
- Paying via check: Make check payable to **Insurance Resource Group**.
- Paying via EFT: Include copy of a voided check with Enrollment Application.
- Monthly invoices are subject to a **\$10.00** Billing Fee.
- No charge** for monthly Electronic Fund Transfers (EFT).
- Must pay first month's (premium, admin fee & one time enrollment fee).
(Association dues are charged on the 1st day of every year. \$20 individuals, \$30 all others)
- Application must be received by the **15th** of prior month to be approved for the 1st of the following month.
- Paying via check:** Mail completed Enrollment Application to:
CPAI
440 S. Federal Highway #207B
Deerfield Beach, FL 33441
- Paying via EFT:** Scan and Email or Fax completed Enrollment Application to:
healthins@cpaint.org
1-954-426-4606
Attn: Enrollment Department

If you need assistance filling out the Enrollment Application, please contact your agent or broker.

Agent/Broker

Telephone:

A Defined Benefit Health Insurance Plan for CPAI Members

Not a Major Medical Health Plan

This product is administered for CPAI by
Insurance Resource Group
20 Madison Avenue
Valhalla, New York 10595

440 s. federal highway
suite 207 b
deerfield beach, fl 33441

SECTION II – Billing Form

Rep Name	Rep Signature	Date	Telephone	Rep Code
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CPAI Select Benefits

Enrollment Worksheet

Effective through 1/31/2007 (Includes PPO Network Charge)

SELECT MONTHLY PREMIUM (Check Appropriate Box)	PLAN I (Silver)	PLANII (Gold)	PLAN III (Diamond)	Rx PLAN OPTIONAL
SUBSCRIBER	<input type="checkbox"/> \$171.75	<input type="checkbox"/> \$219.50	<input type="checkbox"/> \$259.00	<input type="checkbox"/> \$19.95
SUBSCRIBER + 1	<input type="checkbox"/> \$260.75	<input type="checkbox"/> \$348.50	<input type="checkbox"/> \$414.00	<input type="checkbox"/> \$26.95
SUBSCRIBER + 2 or more	<input type="checkbox"/> \$349.75	<input type="checkbox"/> \$477.50	<input type="checkbox"/> \$570.00	<input type="checkbox"/> \$28.95
OPTIONAL Critical Illness for Dependants	<input type="checkbox"/> \$4.75	<input type="checkbox"/> \$9.50	<input type="checkbox"/> \$19.00	

- Step 1. Enter Premium Selected Above: \$ _____
- Step 2. Enter **Dependant** Critical Illness if Selected Above: \$ _____ times number of dependants _____ = \$ _____
- Step 3. Rx Rate Selected Above: \$ _____
- Step 4. Monthly administration fee: \$ 15.00
- Step 5. One time enrollment fee: \$ 60.00
- Step 6. Total Contribution at Enrollment — **Add steps 1 – 5:** \$ _____

PAYMENT OPTIONS (Check Appropriate Box Below)

- ELECTRONIC FUNDS TRAFER (Fill out EFT Authorization Form below)**
INITIAL PAYMENT: Please EFT my bank account for first month's premium, administration fee, and one time enrollment fee. This will occur between the 15th & 20th of the month prior to the effective date (**voided check is required & must be legible**).

MONTHLY PAYMENT: Please EFT my bank account for the monthly premium and administration fee, and my annual association dues. This will occur between the 15th and the 20th of the month prior to the next month's coverage. (**No monthly charge for EFT**).
- CHECK OR MONEY ORDER (Make payable to IRG) Groups**
INITIAL PAYMENT: I am paying my first month's premium, administration fee, and one time enrollment fee via check/money order. I am sending my check or money order with my completed Enrollment Form. **There is a \$30 insufficient funds fee.**

MONTHLY PAYMENT: I would like to receive a monthly invoice to pay my monthly premium and administration fee, and my annual association dues. **I understand an additional monthly fee of \$10 will be charged to me to receive a monthly invoice.**

APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
ACCOUNT HOLDER SIGNATURE (REQUIRED if paying via EFT) X	PRINT NAME	DATE

EFT AUTHORIZATION FORM

BANK NAME	BANK ROUTING NUMBER	BANK ACCOUNT NUMBER
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Voided check is **required** and must be legible. **No monthly charge for EFT.**
 PLEASE ATTACH A CHECK MARKED

VOID

 TO ENSURE ACCURACY

I understand this authority is to remain in full force and effect until the company has received written notification from me of its termination in such time and such manner as to afford the company and depositor a reasonable opportunity to act on it. I have the right to stop payment of a debit entry (deduction) by notification to IRG three days or more before this payment is scheduled to be made. Please be aware that your bank statement will reflect the debit as I.R.G-HEALTH.

ACCOUNT HOLDER SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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