



Consumer Purchasing Alliance

Rx 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.
- Electronic Fund Transfers (EFT) have a \$3.00 Admin fee.
- Monthly invoices are subject to a **\$10.00** Billing Fee.
- 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

Office use only:

Name of Group		Group Number		
Effective Date	Date Submitted	Approved By:	Processed By:	Date Processed:

SECTION I – Enrollment Form – FORM MUST BE FILLED OUT IN BLACK INK – PLEASE PRINT CLEARLY

APPLICATION TYPE OPEN ENROLLMENT ENROLLMENT CHANGE TERMINATION
 (Check Appropriate Box)

REQUESTED EFFECTIVE DATE _____

first day of (mmddyyyy)

(Check Appropriate Box)

APPLICANT NAME Last, First, Middle Initial		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (mmddyy)	SOCIAL SECURITY NO.
STREET ADDRESS		CITY	STATE	ZIP CODE
BILLING ADDRESS / CONTACT / COMPANY (If different than above)			EMAIL ADDRESS	
HOME PHONE	WORK PHONE	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		

**Note: If you are applying for coverage for your spouse and/or children, please list each one below – see Election of Coverage for eligibility.
 Please indicate additional dependants on a duplicate sheet**

LAST NAME	FIRST NAME	RELATION	GENDER	SOCIAL SECURITY NUMBER	BIRTHDATE MMDDYYYY	Check if over 19 & disabled	TERM LIFE BENEFICIARY
SPOUSE		<input type="checkbox"/> WIFE <input type="checkbox"/> HUSB.	<input type="checkbox"/> M <input type="checkbox"/> F				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F				
DEPENDENT		<input type="checkbox"/> SON <input type="checkbox"/> DAUG.	<input type="checkbox"/> M <input type="checkbox"/> F				

ELECTION OF COVERAGE AND AUTHORIZATION*

The applicant in consideration of membership in the Association and participation in the plan hereby acknowledges that the Association, its third party administrator, their agents, owners, successors and assigns assumes no liabilities or obligations other than those specifically identified. I hereby agree to indemnify them from and against any and all claims, damages, losses, costs or expenses (including without limitation, attorneys fees and disbursements) for any claims that may arise by the participation of the plan or membership in the association. All information provided above is true and complete to the best of my knowledge. My signature below also indicates I would like to enroll in the Rx plan I selected above. All applicants must sign below. Any false statement will be cause for immediate cancellation of coverage. It will take one week after your effective date for your cards and provider books to arrive.

APPLICANT SIGNATURE (REQUIRED) X	PRINT NAME	DATE
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