



## 2026 ENROLMENT PACKAGE

Group Health Insurance Plan for members age 65 and over

We are pleased to enclose details of the coverage available under the plan sponsored by the Ordre des CPA.

### ENROLMENT PROCEDURES

To ensure the confidentiality of your personal information, you must submit your enrolment form through the [VIGILIS | Secure portal](#).

To obtain your personalized access, you can complete the [online form](#) or contact the VIGILIS team, the plan administrator, by phone during regular business hours.

The Insurer will accept your request for coverage, without evidence of insurability, if your enrolment form is received **in our offices within 31 days following the termination of your previous group insurance coverage**. Satisfactory evidence of insurability will be required for any request for coverage after this 31-day period.

The Health Insurance Plan is underwritten by Beneva.

**beneva**

For more information, or if you have any questions about the [VIGILIS | Secure portal](#), please contact the VIGILIS team.

**By email:** [cpa@vigilis.ca](mailto:cpa@vigilis.ca)

**By phone:** Monday to Friday between 9 a.m. and 5 p.m. (toll-free): 1-888-682-7772



## THIS PLAN DOES NOT PROVIDE ANY COVERAGE FOR PRESCRIPTION DRUG EXPENSES

### BENEFIT SUMMARY AS OF JANUARY 1, 2026

#### FULL PLAN WITH TRAVEL INSURANCE

#### TRAVEL INSURANCE

##### Reimbursement - No deductible

**100%**

Out-of-province hospitalization and medical expenses resulting from an accident or a sudden illness in case of emergency, including travel assistance, per trip, per insured

First 60 days  
**\$5,000,000** maximum

Trip cancellation and interruption insurance, per trip, per insured <sup>1</sup>

**\$7,500**

<sup>1</sup> In order to be eligible, your plan must be in force at the time one of the insured risks prevents you from traveling.

#### HOSPITALIZATION

##### Reimbursement - No deductible

**100%**

Short-term care

Two beds hospital room

Convalescent or rehabilitation care, per insured, per 12-month period

Two beds hospital room.  
Maximum 180 days

Long-term care, per insured, lifetime maximum

Two beds hospital room.  
Maximum 180 days

Detoxification treatment, per insured, lifetime maximum

**\$80** per day, **\$2,500** maximum

#### VISION CARE

##### Reimbursement - No deductible

**100%**

Eyeglasses, contact lenses or laser eye surgery, per adult, per 24-month period or per 12-month period for children less than 18 years of age

**\$200**

#### HEALTH CARE PROFESSIONALS

##### Reimbursement - No deductible

**80%**

##### Combined maximum for all health care professionals, per insured, per calendar year

**\$1,500**

##### Group 1

Acupuncturist, chiropractor, dietitian, kinesiologist, kinesitherapist, massotherapist, naturopath, osteopath

Combined maximum **\$500**  
Maximum of \$75 per visit

##### Group 2

Audiologist, certified athletic therapist, chiropodist, foot care nurse, occupational therapist, podiatrist, podologist, physical rehabilitation therapist, physiotherapist, speech therapist

Combined maximum **\$750**  
Maximum of \$75 per visit

##### Group 3

Career counsellor, psychiatrist, psychoanalyst, psychoeducator, psychologist, psychotherapist, social worker

Combined maximum **\$1,000**  
Maximum of \$100 per visit

#### OTHER MEDICAL EXPENSES

##### Reimbursement - No deductible

**80%**

Laboratory and diagnostic tests, per insured, per calendar year

Combined maximum **\$1,000**

Hearing aids, per insured, per 36 month-period

**\$250**

Orthopedic shoes, deep shoes and foot orthosis, per insured, per 12-month period

Combined maximum **\$500**

Home care and assistance, per insured, per calendar year

**\$500**

Home nursing care, per insured, per 12-month period

**\$10,000**

#### MONTHLY PREMIUMS AS OF JANUARY 1, 2026 (PRIOR TO THE 9% PROVINCIAL TAX)

INDIVIDUAL	COUPLE	SINGLE PARENT	FAMILY
\$231.22	\$462.44	\$321.30	\$552.52



## Q&A

### 1. What is the deadline for enrolment?

**HEALTH:** The insurer will approve your application for coverage without evidence of insurability if your application form is received, along with the appropriate payment, in our offices within 31 days following the termination of your previous group insurance coverage.

**DENTAL:** The insurer will approve your application for coverage without evidence of insurability if your application form is received, along with the appropriate payment, in our offices within 31 days following the termination of your previous group insurance coverage. It is also possible to add dental coverage each year at the policy anniversary date.

### 2. Can the insurer request evidence of good health at renewal?

No, as long as your premium is received within the 31 day grace period.

### 3. Are premium rates guaranteed?

No. Premium rates are established for all participating members and can increase or decrease according to plan experience.

### 4. What happens if I am no longer a member in good standing of the Ordre des CPA du Québec?

As the plan is exclusively for active and retired members, you would lose your coverage.

# ENROLMENT FORM

## HEALTH INSURANCE FOR MEMBERS AGE 65 AND OVER

### PERSONAL INFORMATION

First name(s):		Name:	
CPA member no. (6 digits and begins with a 4):		Sex: F M	
Date of birth:		Language preference: French English	
Address:			
City:		Province:	Postal Code:
Business telephone no.:	Home telephone no.:		Cellular no.:
E-mail:			

### TYPE OF COVERAGE

Individual

Couple

Single Parent

Family

### INFORMATION RELATING TO YOUR DEPENDENT(S) for insurance purposes

First name(s)	Last name	Relationship to Insured	Date of birth	Sex	Full-time student?
				F M	Yes No
				F M	Yes No

### CHOSEN PLAN

#### FULL PLAN WITHOUT DRUGS (65 AND OVER)

Premiums are subject to change on January 1 each year.

### INFORMATION ABOUT YOUR PREVIOUS INSURANCE COVERAGE

GROUP INSURANCE	TERMINATION DATE:	INSURER OR EMPLOYER:
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### PREMIUM PAYMENT OPTION

MONTHLY BANK WITHDRAWAL	1 - COMPLETE AND SIGN the attached pre-authorized debit (PAD) agreement 2 - INCLUDE a sample cheque
PREMIUM BILLING (CHEQUE)	Annual (premium payable to <b>December 31, 2026</b> )

Please include a cheque, payable to "Gestion VIGILIS", for the appropriate amount as per the monthly premium indicated for the plan of your choice in the enclosed summary. **You must add the 9% Quebec Insurance Tax.**

### AUTORIZATION AND SIGNATURE

I hereby authorize the insurer and VIGILIS Solutions Collectives to obtain and exchange any personal information, including medical information about myself, my spouse or my children, from health professionals, health or social services establishments, public organizations (within the applicable laws), and I authorize these persons to communicate such information to the insurer and to VIGILIS Solutions Collectives for the process of any claim that may be submitted on my behalf under this contract. I also authorize the insurer and VIGILIS Solutions Collectives to communicate details of my coverage to any other Insurance Company or broker as designated by the order.

I understand that I must be a member in good standing of The Ordre des comptables professionnels agréés du Québec to participate in this program.

Member's signature \_\_\_\_\_ Date \_\_\_\_\_

# PRE-AUTHORIZED DEBIT AGREEMENT (PAD)

## IMPORTANT (Please read carefully.)

I/We authorize Gestion VIGILIS, and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin variable deductions as instructed for regular recurring insurance premium payment. Regular monthly payments will be debited to my/our specified account on the 1<sup>st</sup> day of each month. Premiums payments are subject to the insurance provisions outlined in the contract. Gestion Vigilis requires 10 days written notice to make any alterations or changes to this PAD Agreement.

I/We may revoke my/our PAD authorization at any time by providing 10 days written notice. To obtain a cancellation form, or for more information on my/our right to cancel this PAD Agreement, I/we may contact my/our financial institution, Gestion VIGILIS or visit [www.cdnpay.ca](http://www.cdnpay.ca).

Life Insurance, Critical Illness Insurance, Long Term Disability Insurance, Office Overhead Insurance, Health and Dental Insurance Policies.

I/We have waived my/our right to receive pre-notification of the amount of the PAD and agreed that I/we do not require advance notice of the amount of PAD(s) before the debit is processed.

The re-resentation of a payment returned due to not-sufficient funds or funds not cleared can occur only once and must be within 30 days of the original debit. If the payment is returned a second time, the method of premium payment will be altered to annual, direct billing and cannot be changed until the next policy anniversary. The proportion of the annual premium calculated to the next policy anniversary becomes immediately payable. A new PAD Agreement is required to return to the PAD method of payment.

I/We have certain recourse rights if any debit does not comply with this agreement. I/We have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution, Gestion VIGILIS or visit [www.cdnpay.ca](http://www.cdnpay.ca).

If the policy/account is for individual coverage, then the PAD will be setup as a personal PAD and if the policy/account is corporately owned, then the PAD will be setup as a business PAD.

## INSURED / POLICY OWNER INFORMATION (Please print.)

Main insured:

Policy Number(s) or Identification Number:

Policy owner - Name (first and last name) or Full legal name of corporation, including Co., Ltd., Inc., etc.:

Signature of policy owner(s):

Date :

Signature of policy owner(s):

Date :

## PAYOR, ACCOUNT HOLDER INFORMATION (Please print.)

Name (first and last name) or Full legal name of corporation, including Co., Ltd., Inc., etc.:

Address (number, street, apartment number, city, province, postal code):

Category of service:    Personal                      Business

\_\_\_\_\_

Please initial to confirm that you are the only signature authorized for the firm.

Signature of account holder(s):

Date:

Signature of account holder(s):

Date:

## BANK ACCOUNT INFORMATION (Please attach a personalized VOID CHEQUE.)

Name of financial institution (FI):

FI Transit number (branch: 5 digits / institution: 3 digits):

FI Account number:

Address of branch:



## 2026 ENROLMENT PACKAGE

### Group Dental Insurance Plan for members

We are pleased to enclose a Comparison of Benefits for the optional Dental Insurance Plan offered exclusively to the Ordre des CPA du Québec members.

### ENROLMENT PROCEDURES

To ensure the confidentiality of your personal information, you must submit your enrolment form through the [VIGILIS | Secure portal](#).

To obtain your personalized access, you can complete the [online form](#) or contact the VIGILIS team, the plan administrator, by phone during regular business hours.

Dental coverage is available to you upon enrolment in the Health Insurance Plan as long as your request is received **no later than 31 days following termination of your previous group insurance coverage. The original is not required.** It is also possible to add dental coverage each year at the policy anniversary date.

The Dental Insurance Plan is underwritten by Beneva (formerly SSQ Insurance):

**beneva**

For more information, or if you have any questions about the [VIGILIS | Secure portal](#), please contact the VIGILIS team.

**By email:** [cpa@vigilis.ca](mailto:cpa@vigilis.ca)

**By phone:** Monday to Friday between 9 a.m. and 5 p.m. (toll-free): 1-888-682-7772



**BENEFIT SUMMARY UNDER THE GROUP DENTAL INSURANCE PLAN AS OF JANUARY 1, 2026**

	BASIC PLAN	FULL PLAN*
<b>Combined maximum reimbursement per insured, per calendar year</b>	<b>\$1,000</b>	<b>\$1,500</b>
Guide des tarifs de la province où les frais sont engagés, selon la spécialité**	Current year	Current year
<b>Reimbursement</b> - Preventive services - (maximum 2 routine checkups per calendar year) x-rays, diagnostic exams and services	<b>80%</b>	<b>80%</b>
<b>Reimbursement</b> - Basic services - basic restorative services, denture maintenance, oral surgery, anesthesia, extractions	<b>80%</b>	<b>80%</b>
<b>Reimbursement</b> - Endodontic and periodontal services - root canal therapy and treatment of gum disease	<b>50%</b>	<b>50%</b>
<b>Reimbursement</b> - Major restorative services (prosthodontic care) - crowns, implants installed to support dentures, onlays, dentures and bridgework (when required to replace one or more teeth extracted while the person is covered)	n/a	<b>50%</b>
<b>Reimbursement</b> - Orthodontic services (per dependent children aged 6 to 18 when treatment starts)	n/a	<b>50%, Lifetime maximum \$1,500 \$</b>

**MONTHLY PREMIUMS AS OF JANUARY 1, 2026 (PRIOR TO THE 9% PROVINCIAL TAX)**

<b>INDIVIDUAL</b>	\$58.34	\$109.05
<b>COUPLE</b>	\$116.68	\$218.10
<b>SINGLE PARENT</b>	\$84.46	\$149.93
<b>FAMILY</b>	\$142.80	\$258.98

\*

You can opt for the basic plan with any level of coverage under the Health plans. However, the Full Dental plan is only available if you have opted for the Intermediate or Full Health plans.

\*\*

The Provincial Dental Association issues a yearly fee guide for its members. Reimbursement is based on the lower of the incurred cost or the suggested fee as per the most current published fee guide of the province where treatment is rendered, as per the speciality.

# ENROLMENT FORM

## DENTAL CARE

**Candidates for the practice of the profession are not eligible.**

### PERSONAL INFORMATION

First name:

Last name:

CPA member no. (6 digits and begins with a 4):

New member as of:

### SELECT THE DESIRED DENTAL CARE INSURANCE PLAN - PLEASE INITIAL YOUR CHOICE

Premiums are subject to change on January 1 each year.

#### Basic Plan

I understand that I must maintain my coverage for a period of at least two years, except in the event I have access to an other group plan.

I also understand that I will only be able to increase to the Full Plan, once a year, at the policy anniversary date and only if I am covered under the Intermediate or Full Plan for Health Insurance.

PLEASE INITIAL HERE: \_\_\_\_\_

#### Full plan

I understand that I cannot decrease, nor terminate my coverage for a period of at least two years, except in the event I have access to an other group plan.

PLEASE INITIAL HERE: \_\_\_\_\_

**PREMIUM PAYMENT OPTION** The premium payment option will be the same as that of the Health Insurance Plan

### AUTORIZATION AND SIGNATURE

I hereby authorize the insurer and VIGILIS Solutions Collectives to obtain and exchange any personal information, including medical information about myself, my spouse or my children, from health professionals, health or social services establishments, public organizations (within the applicable laws), and I authorize these persons to communicate such information to the insurer and to VIGILIS Solutions Collectives for the process of any claim that may be submitted on my behalf under this contract. I also authorize the insurer and VIGILIS Solutions Collectives to communicate details of my coverage to any other Insurance Company or broker as designated by the order.

I understand that I must be a member in good standing of The Ordre des comptables professionnels agréés du Québec to participate in this program.

**Member signature** \_\_\_\_\_ **Date** \_\_\_\_\_