CPA ORDRE DES COMPTABLES PROFESSIONNELS AGRÉÉS DU QUÉBEC

INSURANCE PLANS

ENROLMENT FORM

DENTAL CARE

Candidates for the practice of the profession are not eligible.

PERSONAL INFORMATION

First name:	Last name:
CPA Client 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**	☐ **Full 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: _____	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** _____