Application for GROUP RETIREE ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE for Retired Members of the AMERICAN POSTAL WORKERS UNION (APWU)

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Underwritten by:
Life Insurance Company of North America
Group Policy # AK-050461

CIGNA®

SECTION A – RETIRED MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Member's Name: _____ (Last Name) _____ (First) _____ (Middle Initial) Social Security Number: _____

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Home/Cell Phone: (_____) _____ E-mail: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female

SECTION B – INSURANCE REQUESTED

SELECT BENEFIT AMOUNT: *(Check one)* ☐ $30,000 ☐ $90,000 ☐ $150,000 ☐ $210,000 ☐ $270,000
☐ $60,000 ☐ $120,000 ☐ $180,000 ☐ $240,000 ☐ $300,000

(Amount of Insurance for Family Members based on composition of Family at time of loss.)

COVERAGE: *(Check one)* ☐ Coverage for RETIRED MEMBER ONLY
☐ Coverage for FAMILY - including Member, Spouse and/or eligible Children

PREMIUM PAYMENT INFORMATION: *(Check one)* ☐ ANNUAL ☐ QUARTERLY ☐ MONTHLY *(Monthly election requires Electronic Funds Transfer Method)*

BENEFICIARY:

Name of Beneficiary _____ Relationship _____

Any accidental death benefit payable at the death of the Member's Spouse or Dependent Child will be paid to the Member or to his/her estate.

If enrolling for FAMILY COVERAGE, please complete the following:

NAME of COVERED FAMILY MEMBER (Last, First, Middle Initial)	DATE of BIRTH (MM / DD / YYYY)
Spouse	/ /
Child	/ /
Child	/ /
Child	/ /

*(**NOTE:** If you need to add more information, please attach a separate sheet if necessary, then sign and date it).*

I hereby enroll in the Accidental Death & Dismemberment Insurance Program underwritten by Life Insurance Company of North America. I understand that the insurance shall become effective on the first day after my premium payment and application is received during my lifetime by the Voluntary Benefits Plan for accidents occurring after the effective date stated in my certificate.

_____ _____/_____/_____
Member Signature X *(Sign in ink)* *Date*