Application for GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE for 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

This is a request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

1. APPLICANT

Name _____

Address _____

City _____

State _____ ZIP _____

Phone Number _____

Local Number _____

Email _____

2. ADDITIONAL INFORMATION

Union Status: ☐ Active ☐ PSE ☐ Retiree ☐ Associate

Date of Birth: _____/_____/_____

Sex: ☐ M ☐ F

Soc. Sec. #: _____

3. NAME YOUR BENEFICIARY

Name _____ Relationship _____

Address _____

City _____ State _____ ZIP _____

☐ Address is the same as Member's

Phone Number _____ _____ %

Name _____ Relationship _____

Address _____

City _____ State _____ ZIP _____

☐ Address is the same as Member's

Phone Number _____ _____ %

4. INSURANCE REQUESTED:

(Refer to the brochure for eligibility and coverage description.)

I hereby apply for the following:

CHOOSE THE TYPE OF COVERAGE THAT BEST MEETS YOUR NEEDS.

☐ Member-only plan
☐ Family Plan

Coverage for FAMILY includes Member, Spouse and/or eligible Children

AMOUNT:
☐ $30,000 ☐ $180,000
☐ $60,000 ☐ $210,000
☐ $90,000 ☐ $240,000
☐ $120,000 ☐ $270,000
☐ $150,000 ☐ $300,000

Please complete the following if you will be selecting the Family Plan:

NAME OF COVERED FAMILY MEMBER (Last, First, Middle Initial)	DATE OF BIRTH (MM / DD / YYYY)	SEX	SOCIAL SECURITY NUMBER
Spouse	/ /	☐ M ☐ F	
Child	/ /	☐ M ☐ F	
Child	/ /	☐ M ☐ F	

5. SIGN AND MAIL THIS FORM TODAY By signing and dating this application, the member attests to being under age 80 and an active APWU member, requests the insurance indicated; and the member and any person proposed for insurance attest to having read the Fraud Notices indicated enclosed, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete. I understand that the insurance shall become effective on the first payday after the premium is deducted from my paycheck and the completed enrollment form is received by the administrator, for covered accidents occurring after the effective date stated in my certificate. I authorize my employer to deduct the insurance premiums from my earnings.

QUESTIONS? CALL TOLL-FREE
1-800-422-4492

Signature (Member) _____ Date _____/_____/_____
(One signature only, please)