

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

Underwritten by:
Life Insurance Company
of North America

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

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

Home Address: _____
Street City State Zip Code

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

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

Are you now at WORK FULL-TIME? Yes No Date of Hire: ____/____/____
(MM/DD/YYYY)

Are you presently insured under any other benefit plans provided by the Voluntary Benefits Plan®? Yes No
 If "Yes," which other plan(s) from Voluntary Benefits Plan® do you have? _____

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

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

BENEFICIARY:

Name of Beneficiary _____ Relationship _____

If enrolling for FAMILY COVERAGE, please complete the following:

NAME of COVERED FAMILY MEMBER (Last, First, Middle Initial)	DATE of BIRTH (MM / DD / YYYY)	SOCIAL SECURITY NUMBER
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 authorize my employer to deduct the premiums from my earnings. I understand that the insurance shall become effective on the first pay-day after the premium is deducted from my pay-check and the completed enrollment form is received by the Voluntary Benefits Plan during my lifetime, for accidents occurring after the effective date stated in my certificate.

Member Signature X (Sign in ink)

_____/_____/_____
 Date