Activation Form for the GROUP CANCER RECOVERY INSURANCE PLAN 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:
American General Life Insurance Company of Delaware
Wiilmington, Delaware
www.americangeneral.com

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Group Policy G-530,027 Certificate No.__________

Member's Name: ____________________ (Last Name, First, Middle Initial) Social Security Number: __________

Home Address: __________ (Street) __________ (City) ____ (State) ______ (Zip Code)

Home E-mail Address: __________

Home Phone: (___) ________ Cell Phone: (___) ________ Fax: (___) ________

Date of Birth: ___ / __ / ____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female

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? __________

MEMBERSHIP STATUS: ☐ Active Member ☐ Associate ☐ PSE

SECTION B – CHOOSE THE PLAN YOU LIKE

BASIC
- ☐ **MEMBER ($9.22 / pay period)**
- ☐ **FAMILY ($17.06 / pay period)**

PREFERRED
- ☐ **MEMBER ($13.37 / pay period)**
- ☐ **FAMILY ($23.06 / pay period)**

If **FAMILY** coverage is requested, write the names of other family members you want to insure:
(Lawful spouse and unmarried dependent children under age 26.)

SPOUSE'S FULL NAME (Last, First, Mid. Init.)				Date of Birth / /	☐ Male ☐ Female
1. (Child Name)	Date of Birth / /	☐ Male ☐ Female	3. (Child Name)	Date of Birth / /	☐ Male ☐ Female
2. (Child Name)	Date of Birth / /	☐ Male ☐ Female	4. (Child Name)	Date of Birth / /	☐ Male ☐ Female

SIGN & MAIL THIS FORM

I hereby enroll with American General Life Insurance Company of Delaware for coverage under the Group Cancer Recovery Insurance Plan. I have read and understand the conditions and exclusions of the program. I authorize payments to be automatically deducted from my paycheck.

Important notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state).

SIGN HERE TO ENROLL > ________________ ___ / __ / ___
Member Signature X *(Sign in ink)* *Date*

QUESTIONS? 1-800-422-4492
Call us Monday through Friday between 8:30 am and 5:00 pm EST
www.VoluntaryBenefitsPlan.com

Group Policy No. G-530,027