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

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

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

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

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 ☐ $60,000 ☐ $90,000 ☐ $120,000 ☐ $150,000 ☐ $180,000 ☐ $210,000 ☐ $240,000 ☐ $270,000 ☐ $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*