


**Application for GROUP RETIREE 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**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Local Number \_\_\_\_\_  
 Email \_\_\_\_\_  
 Soc. Sec. # \_\_\_\_\_

**2. ADDITIONAL INFORMATION**

Union Status:  Retiree  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Sex:  M  F

**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  
 AMOUNT:  \$30,000  \$180,000  
 \$60,000  \$210,000  
 \$90,000  \$240,000  
 \$120,000  \$270,000  
 \$150,000  \$300,000  
**Coverage for FAMILY includes Member, Spouse and/or eligible Children**

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	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	
Child	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	

**5. SIGN AND MAIL THIS FORM TODAY** By signing and dating this application, the member attests to being under age 80 and a dues-paying 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 day after my premium payment and completed enrollment form are received by the administrator, for covered accidents occurring after the effective date stated in my certificate.

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

Signature (Member) \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(One signature only, please)

Group Policy # G-39315-0  
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 TL-007112