Enrollment for the GROUP RETIREE LEGAL SERVICES BENEFIT 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

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

E-mail Address: ______________________

Home/CellPhone:(_____) ______________________

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

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

PREMIUM PAYMENT INFORMATION: *(Check one)* ☐ ANNUAL ☐ QUARTERLY ☐ MONTHLY *(Monthly election requires Electronic Funds Transfer Method)*

I understand that coverage for myself and eligible dependents will become effective 90 days from the first day my premium is received and accepted (except for Domestic Relations which has a 6-month waiting period).

This Plan may be automatically renewed unless further instructions are received under my direction.

______________________ ____ /___ /_____
Member Signature X *(Sign in ink)* *Date*

PLEASE NOTE: You must notify the Voluntary Benefits Plan of any address change, employment or union membership status change, life status change (i.e., marriage, divorce, beneficiary or name change) or benefit changes requested. Notice must be in writing.

NOTE: *If you have made corrections or strikeouts on this application, the Member MUST initial them.*