New York Professional Fire Fighters Association

Voluntary Life & AD&D

One-Time Open Enrollment with MetLife

ENROLLMENT PERIOD: September 1, 2017 to September 30, 2017

For Those Not Currently Enrolled:

You may enroll for a benefit up to $120,000 **without** completing a Statement of Health form.*

	Member	**Spouse & Child**	
	Member	Spouse	Child*
Eligibility	**Active, full time members who work 20 hours or more per week.**	**Member must be enrolled. Amounts over $20,000 not to exceed 50% of employee's supplemental life benefit**	**Up to age 24 when enrolled full time at an accredited college or university**
Life Coverage: provides a benefit in the event of death Schedules:	**$30,000, $60,000, $120,000, $180,000, $240,000 or $300,000**	**$20,000, $30,000, $60,000, $90,000, $120,000, $150,000**	**$10,000**
Overall Benefit Maximum	**$300,000**	**$150,000**	**$10,000**
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident	**100% of the Supplemental Life Benefit**	**N/A**	**N/A**
Conversion/Portability	**Included**	**Included**	**Included**

***Included with Spouse coverage**

For Those Members Currently Enrolled:

Enrolled under $120,000

You have the opportunity to increase your benefit up to $120,000 **without** a Statement of Health form.*

Enrolled $120,000 or more

You have the opportunity to increase your benefit by one increment **without** completing a Statement of Health Form.* *(example: a member's current insurance is $180,000. That member can increase their coverage to $240,000, without completing a Statement of Health Form)*

***If you have been hospitalized in the past 90 days a Statement of Health form will be required.**

NEW YORK STATE PROFESSIONAL FIRE FIGHTERS ASSOCIATION
174 WASHINGTON AVENUE
ALBANY, NEW YORK 12210
518-436-8827, EXTENSION 201

Monthly Life Insurance Rates - Active Members

Age	Total Active Member Coverage: 30,000	60,000	120,000	180,000	240,000	300,000
18-34	$ 4.93	$ 9.85	$ 19.70	$ 29.55	$ 39.40	$ 49.25
35-59	$ 6.63	$ 13.25	$ 26.50	$ 39.75	$ 53.00	$ 66.25
60-69	$ 8.35	$ 16.70	$ 33.40	$ 50.10	$ 66.80	$ 83.50

Monthly Life Insurance Rates - Spousal Coverage

Age	Total Spousal Coverage: 20,000	30,000	60,000	90,000	120,000	150,000
<=29	$ 4.00	$ 4.69	$ 6.76	$ 8.83	$ 10.90	$ 12.97
30-34	$ 4.00	$ 4.70	$ 6.80	$ 8.90	$ 11.00	$ 13.10
35-39	$ 4.00	$ 4.93	$ 7.72	$ 10.51	$ 13.30	$ 16.09
40-44	$ 4.00	$ 5.30	$ 9.20	$ 13.10	$ 17.00	$ 20.90
45-49	$ 4.00	$ 5.97	$ 11.88	$ 17.79	$ 23.70	$ 29.61
50-54	$ 4.00	$ 7.01	$ 16.04	$ 25.07	$ 34.10	$ 43.13
55-59	$ 4.00	$ 9.00	$ 24.00	$ 39.00	$ 54.00	$ 69.00
60-64	$ 4.00	$ 11.56	$ 34.24	$ 56.92	$ 79.60	$ 102.28
65-69	$ 4.00	$ 16.84	$ 55.36	$ 93.88	$ 132.40	$ 170.92

* Spouse Rates above include Spouse and $10,000 in Dependent Child coverage
** Total amount of Spouse only coverage cannot exceed more than 50% of member's coverage.
***If you apply for Spousal coverage in excess of $20,000, you need to fill out a Statement of Health Form (MetLife Life Medical Form) found at <www.nyspffa.org>.

Submission Instructions:

Return via Mail or Fax To

NEW YORK STATE PROFESSIONAL FIRE FIGHTERS ASSOCIATION

174 WASHINGTON AVE - ALBANY - NY - 12210

O - 518.436.8827 F - 518.436.8830

Local #: _________________ Membership Date: __________________ Job Title: ____________________________

Member's Full Name (please print) ____
First Middle Last

Home Address ____
Number Street City State Zip

Telephone Number _________________________ Email Address ___________________________________

New Enrollment Beneficiary Change Other Change: _____________________

Voluntary Amounts Available

Select coverages amounts, Indicate total amount of coverage requested spousal coverage can not exceed 50% of members coverage.
This coverage includes AD&D benefit. For full coverage details please see plan documents.

Member		Spouse		Child(ren)
$30,000	$180,000	$20,000	$90,000	$10,000
$60,000	$240,000	$30,000	$120,000	Decline
$120,000	$300,000	$60,000	$150,000	
Decline		Decline		

Covered People

Complete the following for member, spouse, and dependent child(ren) requesting coverage

	Name	Date of Birth	Gender (M/F)	Social Security #
Member				
Spouse				
Child(ren)				
Child(ren)				
Child(ren)				

Beneficiary Designation*

(Designations are not valid unless signed, dated and delivered to the NYSPFFA office at the address listed on this form)

	Name	Relationship to Member	% of Benefit	Social Security #
Primary				
Primary				
		Total (must equal 100%)		

	Name	Relationship to Member	% of Benefit	Social Security #
Contingent				
Contingent				
		Total (must equal 100%)		

*if more space is needed use the back of this form

___________________________________ ________________

Member Signature Date