

American General

Life Companies

Group Employee Enrollment Form

The United States Life Insurance Company in the City of New York

New York, New York

Administrative Office: New York State Professional Fire Fighters Association

Attn: Plan Administrator 174 Washington Avenue, Albany, NY 12210

Completing Your GROUP ENROLLMENT FORM 1. Fully complete each section 2. Sign and date Refusal/Authorization Section, as needed.				Group Policy No.(s) V255769		<input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> CHANGE IN ENROLLMENT			
1. PERSONAL DATA: (Must always be completed)									
IAFF Local #		Class	Social Security No.			Last Name		First Name	Initial
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM DD YY		Street Address			City	State	Zip Code	Phone Number
Name of Employer NYSFFA				Location			Salary \$ Per		
Occupation			Title		Membership Date	MM DD YY	No. Hours Worked Per Week	<input type="checkbox"/> Union <input type="checkbox"/> NonUnion	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Dependent Children No <input type="checkbox"/> Yes <input type="checkbox"/>			If Yes, #				
2. ENROLLMENT									
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.									
Name	Relationship	Self	Sp.	Ch.	Date of Birth	MM/DD/YY	Sex		
SELF	X								
3. Select amount requested for Employee:									
<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$60,000	<input type="checkbox"/> \$120,000	<input type="checkbox"/> \$180,000	<input type="checkbox"/> \$240,000	<input type="checkbox"/> \$300,000				
4. Select amount requested for Spouse:									
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$60,000	<input type="checkbox"/> \$90,000	<input type="checkbox"/> \$120,000	<input type="checkbox"/> \$150,000				
5. Beneficiary Designation: as is									
EX: MARY A. JONES, WIFE		First Name	Initial	Last Name		Relationship			
NOT MRS. JOHN JONES									
6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)									
I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by UNITED STATES LIFE.									
I am refusing: <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> All coverages offered									
MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:									
Are you or your dependents now covered by any other group plan?				<input type="checkbox"/> YES	<input type="checkbox"/> NO	(Your dependent(s) may be insured by this Plan even if they are insured elsewhere)			
If Yes: Policyholder's Name _____				Carrier _____					
I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.									
If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage. I must furnish, at my expense, evidence of insurability satisfactory to United States Life if I later wish to enroll in any other coverage that is now being refused.									
_____ DATE OF REFUSAL				_____ SIGNATURE IF REFUSING ANY COVERAGE					
*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.									
7. AUTHORIZATION:									
<ul style="list-style-type: none"> I hereby certify that all information furnished is true to the best of my knowledge. I request group insurance for which I am or may become eligible. If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to The United States Life Insurance Company in the City of New York. 				<ul style="list-style-type: none"> I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death. If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by United States Life. I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to United States Life information about me. Such information will pertain to my employment or other insurance coverage. 					
_____ DATE SIGNED				_____ APPLICANT'S SIGNATURE					

Member's Full Name	Social Security Number	Street Address, City, State, & Zip	Phone #	IAFF Local #
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Beneficiary Designation: as is

Designations are not valid unless signed, dated and delivered to the New York State Professional Fire Fighters Association, Inc. during your lifetime.

Primary Beneficiary:

Full Name	Social Security Number	Relationship	% of Benefit

Contingent Beneficiary:

Full Name	Social Security Number	Relationship	% of Benefit

Member's Signature: _____ Date: _____

- The most recent designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if all primary Beneficiaries are deceased.
- If you name two or more Beneficiaries in a class:
 - Two or more surviving Beneficiaries will share equally, unless you specify unequal shares.
 - If you provide for unequal shares in a class, and two or more beneficiaries in that class survive, the benefit will be paid to each surviving Beneficiary their designated share. Unless you provide otherwise, the benefit will then be paid the share(s) otherwise due to any deceased Beneficiary (ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 - If only one Beneficiary in a class survives, the total benefit will then be paid to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions. Consult your legal advisor.
- Dependent Insurance, if any, is payable to you, if living, or as provided under Employer's coverage under the Group Policy.

Return completed form to:
 New York State Professional Fire Fighters Association, Inc.
 174 Washington Ave.
 Albany, NY 12210