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 119 Washington Ave., Suite 306 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	☐ **NEW ENROLLMENT** ☐ **CHANGE IN ENROLLMENT**

1. PERSONAL DATA: (Must always be completed)

IAFF Local #	Class	Social Security No.	Last Name	First Name	Initial

Sex ☐ Male ☐ 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 ____ ☐ Union ☐ NonUnion

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Dependent Children No ☐ Yes ☐ 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:

☐ **$30,000** ☐ **$60,000** ☐ **$120,000** ☐ **$180,000** ☐ **$240,000** ☐ **$300,000**

4. Select amount requested for Spouse:

☐ **$20,000** ☐ **$30,000** ☐ **$60,000** ☐ **$90,000** ☐ **$120,000** ☐ **$150,000**

5. Beneficiary Designation: as is

EX: MARY A. JONES, WIFE NOT MRS. JOHN JONES	First Name	Initial	Last Name	Relationship
	----------Please See Attached Form----------			

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: ☐ Life/AD&D ☐ Dependent Life ☐ 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? ☐ YES ☐ 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:

- 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.
- 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 #

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
Full Name	Social Security Number	Relationship	% of Benefit

Contingent Beneficiary:

Full Name	Social Security Number	Relationship	% of Benefit
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.
119 Washington Ave., Suite 306
Albany, NY 12210