NYSCOPBA OPTIONAL Term Life and Disability Insurance Enrollment Form

If questions, please call Norvest Financial Services toll free - 1-888-869-8252

PLANHOLDER NAME	GROUP PLAN NO.	PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP
NYSCOPBA	645228	C/O NORVEST FINANCIAL SERVICES 930 Albany Shaker Road	Latham	NY	12110

MEMBER'S NAME (LAST, FIRST, MI)	SOC. SEC. NO.	BIRTHDATE	SEX

MEMBER'S STREET ADDRESS	CITY	STATE	ZIP

PREFERRED TELEPHONE NUMBER	ARE YOU WORKING 20 OR MORE HOURS A WEEK?
	☐ YES ☐ NO

BENEFICIARY DESIGNATION: NYSCOPBA'S FREE $30,000 BASIC LIFE AND $30,000 ACCIDENTAL DEATH (AD&D)

Primary: ______________________ **Relationship:** ______________________

Contingent: ______________________ **Relationship:** ______________________

OPTIONAL TERM LIFE INSURANCE

Member coverage required for Spousal and/or Child coverage
Spousal coverage amount cannot exceed Member amount
Election amounts in the shaded area require a Medical History Statement - Call 1-888-869-8252 for assistance

Step 1: **I elect Optional Term Life Insurance:** ☐ Yes ☐ No **If yes, please elect Member Amount:**

5,000 $100,000 $125,000 50,000

☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

Step 2: **I elect Spouse Coverage:** ☐ Yes ☐ No **If yes, please elect Spouse Amount:** – If spouse is also a NYSCOPBA Member, please call Norvest at 1-888-869-8252

☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

Spouse Name: ______________________ **Sex** ☐ **M** ☐ **F** **Date of Birth:** ______________

Step 3: **I elect Child(ren) Coverage:** ☐ Yes ☐ No **If yes, please check:** ☐ **$4,000 (only available amount)**

Child Name: ______________________ **Sex** ☐ **M** ☐ **F** **Date of Birth:** ______________

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Child Name: ______________________ **Sex** ☐ **M** ☐ **F** **Date of Birth:** ______________

Step 4: **I elect Accidental Death and Dismemberment Rider:** **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

BENEFICIARY DESIGNATION for OPTIONAL TERM LIFE INSURANCE (only if different from above)

Primary: ______________________ **Relationship:** ______________________

Contingent: ______________________ **Relationship:** ______________________

OPTIONAL DISABILITY INSURANCE

Step 1: **I elect Optional Disability Insurance:** ☐ Yes ☐ No **If yes, please elect a WAITING PERIOD:**

☐ 30 DAYS ☐ 60 DAYS

Step 2: **Elect your monthly benefit amount:**

☐ $800 ☐ $1,000 ☐ $1,200 ☐ $1,400 ☐ $1,600 ☐ $1,800 ☐ $2,000

A Medical History Statement must be completed to purchase the shaded amounts.

I understand that I must be a Member of NYSCOPBA and actively working at least 20 hours per week to be eligible

Signature of Member **Date**

______________________________ ______________________

Please retain the yellow copy for your records.

06/2014