

UNION PLUS GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ENROLLMENT FORM

1.

_____ Please check desired coverage (✓) _____

Benefit Amount*	Union Member Only**	Union Member and Family**
\$200,000	<input type="checkbox"/> \$51.21	<input type="checkbox"/> \$68.70
\$175,000	<input type="checkbox"/> \$45.29	<input type="checkbox"/> \$60.60
\$150,000	<input type="checkbox"/> \$39.39	<input type="checkbox"/> \$52.50
\$125,000	<input type="checkbox"/> \$33.48	<input type="checkbox"/> \$44.40
\$100,000	<input type="checkbox"/> \$27.56	<input type="checkbox"/> \$36.30
\$75,000	<input type="checkbox"/> \$21.63	<input type="checkbox"/> \$28.20
\$50,000	<input type="checkbox"/> \$15.72	<input type="checkbox"/> \$20.10
\$25,000	<input type="checkbox"/> \$9.81	<input type="checkbox"/> \$12.00

*At age 70, or if you are already age 70, all coverage is reduced by 50%. Rates and/or benefits may be changed on a class basis. The family Plan protects spouse and children at a percentage of your coverage amount.

**These are premiums for Expanded Coverage for 3 months. You will be billed quarterly.

My Beneficiary for coverage selected _____
(first, middle, last)

2.

Member's Date of Birth **X** _____
(mo / day / yr)

Preferred Phone Number _____

Email Address (optional) _____

First name _____

Last name _____

Address line 1 _____

Address line 2 _____

City _____ State _____ Zip _____

International union _____

Local union number _____

3.

I hereby enroll with Hartford Life and Accident Insurance Company of Hartford, CT, 06155 for coverage under the Accidental Death and Dismemberment Plan, ADD-9920. I have read and understand the conditions and exclusions of the program. I understand that my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my first premium payment.

Signature **X** _____ Date **X** _____

Underwritten by: Hartford Life and Accident Insurance Company, Hartford CT 06155
Policyholder: AFL-CIO Mutual Benefit Fund

TO ENROLL: Please make check payable to: AFL-CIO Mutual Benefit Fund.
Mail it along with your completed Enrollment Form to Union Plus Insurance Program, PO Box 47060, Phoenix, AZ 85068-7060.
Questions? Call 1-866-557-5209 8a.m.-7p.m. EST, Mon-Fri.