



## UNION PLUS TRAVEL ACCIDENT INSURANCE PLAN ENROLLMENT FORM



ADD-9940

### Choose your Coverage and Benefit Level:

- |                                                                                                                                                       |                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| ▶ <b>\$50,000 Accidental Death Coverage</b> PLUS \$500 per day for both Hospitalization and Recuperation AND \$250 per occurrence for Outpatient Care | <input type="checkbox"/> Member . . . . . \$60.00 semi-annually<br><input type="checkbox"/> Family . . . . . \$94.50 semi-annually |
| ▶ <b>\$40,000 Accidental Death Coverage</b> PLUS \$400 per day for both Hospitalization and Recuperation AND \$200 per occurrence for Outpatient Care | <input type="checkbox"/> Member . . . . . \$48.00 semi-annually<br><input type="checkbox"/> Family . . . . . \$75.60 semi-annually |
| ▶ <b>\$30,000 Accidental Death Coverage</b> PLUS \$300 per day for both Hospitalization and Recuperation AND \$150 per occurrence for Outpatient Care | <input type="checkbox"/> Member . . . . . \$36.00 semi-annually<br><input type="checkbox"/> Family . . . . . \$56.70 semi-annually |

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

International Union: \_\_\_\_\_

Local Union Number: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Preferred Phone Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Your Beneficiary: \_\_\_\_\_

- ▶ **Complete and Return to:** Union Plus Insurance Program  
P.O. Box 47060  
Phoenix, AZ 85068-9963

YOU WILL BE BILLED SEMI-ANNUALLY FOR YOUR CONVENIENCE.

- ▶ Remember to enclose your check payable to the  
**AFL-CIO Mutual Benefit Trust.**

I hereby enroll with Hartford Life and Accident Insurance Company of Hartford, CT, for coverage under the Accidental Death and Dismemberment Plan, ADD-9940. 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.

**UNION MEMBER'S SIGNATURE:****X**

(Required)

(Date)

Accident Form Series includes GBD-1000, GBD-1300, or state equivalent.  
Underwritten by Hartford Life and Accident Insurance Company, Hartford, CT 06155

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**

**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- hospice
- other approved items and services

**Before You Buy This Insurance**

- ✓ Check the coverage of **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

**Form PA-9055**