

# ENROLLMENT FORM FOR PERSONAL ACCIDENT INSURANCE

Underwritten by: AIG Life Insurance Company

Complete the following to enroll:

Company Name: PSEA Master Policy #: SRG 806 42 70

Employee's Full Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Date of Birth: \_\_/\_\_/\_\_ Date Employed: \_\_/\_\_/\_\_ Occupation: \_\_\_\_\_

Effective Date - For Official Use Only

Select Coverage Option: PSEA Member Benefit Amount \$ \_\_\_\_\_

Option 1 - Member Only Coverage

Option 4 - Member & Dependent Child(ren) Only Coverage

Option 2 - Member & Spouse Only Coverage at 100%

Option 5 - Member, Spouse at 100%, & Dependent Child(ren) Family Coverage

Option 3 - Member & Spouse Only Coverage at 50%

Option 6 - Member, Spouse at 50%, & Dependent Child(ren) Family Coverage

I am covering a Domestic Partner, please send me the required Affidavit.

*If you select coverage for your family, benefits for family members will be a percentage of yours.*

*If you insure your spouse/domestic partner, you are his/her beneficiary unless you specify otherwise in writing. If more than one beneficiary, please note on a separate sheet of paper.*

Employee Beneficiary's Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Social Security Number: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

**Your Effective Date:** Your coverage will begin on the later of: 1) the Policy Effective date; 2) the date this Enrollment Form is received by PSEA.

I enroll and authorize PSEA to deduct the premiums from my earnings for the insurance applied for as shown above.

I have been given the opportunity for this insurance but I do not desire to participate.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_