

NYSCOPBA Disability Insurance Enrollment Form

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

AREAS IN RED MUST BE COMPLETED IN ORDER TO PROCESS YOUR APPLICATION

PLANHOLDER NAME NYSCOPBA	PLANHOLDER STREET ADDRESS C/O NORVEST, 930 ALBANY SHAKER ROAD	CITY LATHAM	STATE NY	ZIP CODE 12110
MEMBER'S NAME (LAST, FIRST, MI)		SOC. SEC. NO.	BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MEMBER'S STREET ADDRESS		CITY	STATE	ZIP CODE
PREFERRED TELEPHONE NUMBER		Are you currently working 20 or more hours per week? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DISABILITY INSURANCE

Step 1: CHOOSE YOUR WAITING PERIOD

30 DAY 60 DAY

Step 2: CHOOSE YOUR MONTHLY BENEFIT AMOUNT

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

In addition: If you haven't elected or wish to update your BENEFICIARY DESIGNATION for NYSCOPBA'S FREE \$15,000 BASIC LIFE and FREE \$26,000 AD&D INSURANCE, please complete below:

Completing these designations revokes all prior designations.

PRIMARY	RELATIONSHIP
CONTINGENT	RELATIONSHIP

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

SIGNATURE OF MEMBER	DATE
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