NYSCOPBA OPTIONAL Term Life Insurance Enrollment and Beneficiary 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?
	SINGLE ☐ MARRIED ☐	WIDOWED ☐ DIVORCED ☐	DOMESTIC PARTNER ☐	☐ YES ☐ NO

OPTIONAL TERM LIFE INSURANCE

Member coverage required to select Spousal/Domestic Partner and/or Child coverage
Spousal/Domestic Partner 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:**

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

Step 2: **I elect (check box): Spouse ☐ Domestic Partner ☐ Please elect Amount:** – If spouse/domestic partner 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/Domestic Partner Name:_____ **Sex ☐ M ☐ F Date of Birth:**_____

Step 3: **I elect Accidental Death and Dismemberment Rider: Member ☐ Yes ☐ No Spouse/Domestic Partner ☐ Yes ☐ No**

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

Child Name:_____ **Sex ☐ M ☐ F Date of Birth:**_____

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

Primary: _____ **Relationship:** _____

Contingent: _____ **Relationship:** _____

BENEFICIARY DESIGNATION for OPTIONAL TERM LIFE INSURANCE (only if different from the Basic Life Designation above)

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

_____ _____

Signature of Member **Date**

Please retain the yellow copy for your records.

11/2020