

Enrollment Form for FACCC Group Accidental Death & Dismemberment Insurance Coverage

Underwritten by: Life Insurance Company of North America

New Applicant Change to Existing Coverage (Indicate additional amounts only)

Member's Full Name: (Last, First, MI) _____

Address: _____ City: _____ State: _____ Zip: _____

Member is: Female Male

Marital Status: Single Divorced Widowed Married Legally Separated

Home Telephone Number: _____ Date of Birth: _____ Email Address: _____

Social Security Number: _____ College District/Employer: _____

Your Beneficiary: _____ Relationship to you: _____

You are the beneficiary for your covered spouse and/or children.

PLAN	1 UNIT			2 UNITS			3 UNITS		
	MEMBER	SPOUSE	ea. CHILD	MEMBER	SPOUSE	ea. CHILD	MEMBER	SPOUSE	ea. CHILD
A	\$50,000	\$0	\$0	\$100,000	\$0	\$0	\$150,000	\$0	\$0
B	40,000	10,000	0	80,000	20,000	0	120,000	30,000	0
C	25,000	25,000	0	50,000	50,000	0	75,000	75,000	0
D	30,000	10,000	5,000	60,000	20,000	10,000	90,000	30,000	15,000
E	20,000	20,000	5,000	40,000	40,000	10,000	60,000	60,000	15,000
F	40,000	0	5,000	80,000	0	10,000	120,000	0	15,000
	\$3.00 Monthly \$3.60 Tenthly			\$6.00 Monthly \$7.20 Tenthly			\$9.00 Monthly \$10.80 Tenthly		
PLAN	4 UNITS			5 UNITS			6 UNITS		
	MEMBER	SPOUSE	ea. CHILD	MEMBER	SPOUSE	ea. CHILD	MEMBER	SPOUSE	ea. CHILD
A	\$200,000	\$0	\$0	\$250,000	\$0	\$0	\$300,000	\$0	\$0
B	160,000	40,000	0	200,000	50,000	0	240,000	60,000	0
C	100,000	100,000	0	125,000	125,000	0	150,000	150,000	0
D	120,000	40,000	20,000	150,000	50,000	25,000	180,000	60,000	30,000
E	80,000	80,000	20,000	100,000	100,000	25,000	120,000	120,000	30,000
F	160,000	0	20,000	200,000	0	25,000	240,000	0	30,000
	\$12.00 Monthly \$14.40 Tenthly			\$15.00 Monthly \$18.00 Tenthly			\$18.00 Monthly \$21.60 Tenthly		

Check No. of Units Desired 1 2 3 4 5 6 Check Plan Desired A B C D E F
 Preferred Premium Mode: Monthly Tenthly (Please be sure to complete the Payroll Withholding Authorization Form)

If Family Coverage is requested (Plans B-F), please list eligible dependents (if additional space needed, use reverse side):

Relationship to member	Name (First, MI, Last)	Sex	Date of Birth	Social Security Number
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		
Child		<input type="checkbox"/> M <input type="checkbox"/> F		

I hereby apply to the Life Insurance Company of North America for accidental death & dismemberment insurance under Group Master Policy AK-050293 issued to the Universal Protection Trust, the group policyholder. I certify that I do not already have coverage under another group accidental death & dismemberment policy issued by Life Insurance Company of North America to the group policyholder.

I understand that coverage will begin on the effective date shown on my Certificate of Insurance and is subject to receipt of my first premium payment by the Administrator.

Your Signature **X** _____

Date _____

PAYROLL WITHHOLDING AUTHORIZATION

Employee Name (First) (M.I.) (Last)

Social Security No. District/Employer

Payment Mode Selected: Tenthly Monthly

Total Initial Premium To Be Deducted: _____

I hereby authorize my employer to make applicable deductions for the insurance applied for:

Employees Signature _____

Date _____

HOME OFFICE USE ONLY: Approved Date: _____

DISABILITY INCOME INSURANCE

Amount of Monthly Benefit: \$ _____

Plan Desired: PLAN A

PLAN B

PLAN C - Waiting Period Selected:

90 180 365

TERM LIFE INSURANCE

Amount of Insurance - Member: _____

Amount of Insurance - Spouse: _____

Amount of Insurance - Child(ren): \$5,000 \$10,000

FAMILY ACCIDENT INSURANCE

PLAN: A B C D E F

UNITS: 1 2 3 4 5 6