

CALIFORNIA PROFESSIONAL FIREFIGHTERS
VOLUNTARY GROUP LIFE WITH MATCHING AD&D
ENROLLMENT/CHANGE FORM
 Group Policy #05339281

Mail to: CPFHBT
PO Box 27020
Fresno CA 93729-7020
Fax: 559-440-9752
Ph: 800-549-4242
www.cpf-insurance.com

Member Information

Local #: _____

Last Name	First Name	MI	Social Security Number
Mailing Address _____			
Street	City	St	Zip
Street Address (if different than above) _____			
Street	City	St	Zip
Birth Date	Gender	Home Phone	Work Phone
Email Address _____			
Hire Date	Classification	Monthly Base Salary	

Coverage Information - \$10,000 - \$500,000 (increments of \$10,000)

Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse or children.

Check the boxes that apply:

- VGM-NT Voluntary Group Life Member – Non-Smoker
- VGM-T Voluntary Group Life Member – Smoker
- VGS-NT Voluntary Group Spouse – Non-Smoker
- VGS-T Voluntary Group Spouse – Smoker
- VG-C Dependent Child(ren) – \$5,000 - \$0.90/Month

- | | |
|--|--|
| <i>Member</i> | <i>Spouse</i> |
| <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$25,000 |
| <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$50,000 |
| <input type="checkbox"/> \$250,000 | * <input type="checkbox"/> Other: \$ _____ |
| * <input type="checkbox"/> Other: \$ _____ | |

*See Guaranteed Issue Limits. If amount requested is in excess of amount shown you MUST complete the evidence of Insurance and HIPPA forms. Ask your representative or see website for the forms.

Received notice of Information Privacy Practices? Yes No

Are you applying for spouse coverage? Yes No

Have you or your spouse smoked in the past 12 months? **Member** Yes No **Spouse** Yes No

If you checked "yes" to apply for spouse or child(ren) coverage, please complete the following:

Name of Dependent	Relationship	Age	Date of Birth
First MI Last			Mo Day Year

Beneficiary Information

Primary Beneficiary: _____
 First MI Last Relationship

Contingent Beneficiary: _____
 First MI Last Relationship

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to California Professional Firefighters Health Benefits Trust (CPFHBT) by MetLife Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date that my insurance would otherwise become effective, I shall only become insured on the date that I return to active, full-time work. I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to MetLife. MetLife Statement of Health form GEF08-1 must be completed by all late applicants.

Member's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Yes, please contact me about other benefits offered by the CPF Health Benefits Trust

Notice to California Residents: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Authorization for Payroll Deduction: _____ YES _____ NO

(if available through Local; for any questions, please call CPFHBT Administrator at 1-800-549-4242)

On the reverse side of this form I have applied for insurance for which I am now eligible under the provisions of the Group Policy issued to my employer and I authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

Member's signature: _____ **Date:** _____

Authorization for Automatic Bank Deduction: _____ YES _____ NO

I authorize Harry J. Wilson INSURANCENTER, Inc. (HJWII) to initiate debits for premiums due against the account shown below. I understand that I will receive no notification from HJWII if the amount of a withdrawal changes by less than one dollar as compared to my last withdrawal. The withdrawal will be made on one of the following business days: (check one)

_____ 5th of the month **OR** _____ 15th of the month

I may withdraw this authorization by giving written notice to HJWII in such time and manner as to afford HJWII and the Bank reasonable time to act upon the request. Similarly, HJWII may terminate this agreement with me by written notice.

Required Information for Automatic Bank Deduction:

(Check marked VOID must be attached)

Insured Name: _____

ABA Transit Number: _____ Account Number: _____
(first 9 digits from the left)

Financial Institution Name: _____

Financial Institution Address: _____

Member's Signature: _____ **Date:** _____

Signature (if joint account): _____ **Date:** _____