



Personal Accident Insurance Enrollment/Change Form

Mail to:
CPF Health Benefits Trust
Harry J. Wilson Insurancenter Inc.
P.O. Box 27020
Fresno, CA 93729-7020
1-800-549-4242 Fax 559-440-9752
www.cpf-insurance.com

CPF Local Name & Number: _____

Member's Name: _____
Last First M.I.

Address: _____
Street

Date of Birth: _____ Soc. Sec. No: ____/____/____
mm/dd/yyyy

Home Phone: (____) _____ Work Phone: (____) _____

E-mail Address: _____

Check Choice of Plan: (check appropriate box(es))

- Member Only (Class I)
- Buy-Up Coverage (Class II - Optional)
- Family Plan (Class III)

Check Benefit Amount:

- \$100,000
- \$200,000
- \$300,000
- \$400,000
- \$500,000
- Other \$ _____
Not to exceed \$500,000

Beneficiary: _____/_____
Name Relationship

The beneficiary of the spouse and dependent child(ren) will be the insured member unless otherwise requested in writing to the Insurance Company.

Spouse:

Name: _____
Last First M.I.

Date of Birth: _____ Soc. Sec.# ____/____/____

Child(ren)

Name: _____
Last First M.I.

Date of Birth: _____ Soc. Sec.# ____/____/____

Name: _____
Last First M.I.

Date of Birth: _____ Soc. Sec.# ____/____/____

Name: _____
Last First M.I.

Date of Birth: _____ Soc. Sec.# ____/____/____

I acknowledge that I have read, understand, and agree to the terms and conditions of this coverage as detailed in the handout and I authorize the premium deduction from my pay for the insurance applied for as shown above. I understand that if I purchase more than I am allowed, any excess premiums will be refunded.

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

Member's Signature: _____

Date Signed: _____

Requested Effective Date of Coverage (mm/yyyy): _____

Administrator:



Two Rincon Center / 121 Spear Street / San Francisco, CA 94105-1588

