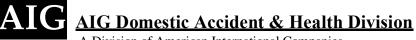


Personal Accident Insurance Enrollment/Change Form

Mail to: CPF Insurance Trust PTW Insurance Services P.O. Box 27098 Fresno, CA 93729-7098 1-888-550-5000 Fax (888) 273-6630

Local:						
Memberos Name	e:					
Address:	Last, First M.I.					
Date of Birth:			Soc. Sec. No: _	/	/	
mm / dd / yyyy Home Phone: ())		
E-mail Address:						
Check Choice of	of Plan: (che	ck appropriate k	oox(es)			
Member Only (Class I)	☐ Bu (Clas	y-Up Coverage s II - Optional)	Family Plan (Class III)			
Check Benefit	Amount:					
□ \$100,000	□ \$200,000	∎\$300,000	∎\$400,000	∎\$500,000	□Other \$ Not to exceed \$500,	
Beneficiary:			Relationship:			
The beneficiary o Insurance Compa			ren) will be the insured	l member unless o	otherwise requested i	n writing to the
Spouse:	Last, First, M.I.					
Date of Birth:			Soc. Sec. No: _	/	/	
Child(ren):	тт 7 аа 7 уууу					
Name:	Last First MI					
Date of Birth:			Soc Sec No.		/	
	mm / dd / yyyy		000. 000. No	//	/	
Name:	Last, First, M.I.					
Date of Birth:			Soc. Sec. No: _	/	/	
Name:	mm / dd / yyyy					
	Last, First, M.I.					
Date of Birth:			Soc. Sec. No: _	/	/	
I acknowledge	that I have read, u nium deduction fro	nderstand, and age m my pay for the ir	ree to the terms and cor nsurance applied for as			
I have been giv	en the opportunity	for this insurance	but I <u>do not desire to p</u>	participate.		
Member's Signat	ure:			Date:		
Requested Effectiv	ve Date of Covera	ge (mm/yyyy):			Admii	nistrator:



CA. License #6001998

A Division of American International Companies Two Rincon Center / 121 Spear Street / San Francisco, CA 94105-1588