

This Box for ACWA JPIA Use Only		
Loc. No.:	Eff. Date:	Group No.: 649298
Plan Code No.:	Entered:	<input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Delete

I. SELECTED COVERAGE

Benefit Level:	Director: <i>(Maximum – \$10,000)</i>	Dependent Coverage:	Additional Coverage: If yes, complete "Medical History Statement" form and submit for approval.
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No			

II. PERSONAL INFORMATION

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's Last Name:	First Name:	M.I.:
Birth Date: <i>(Mo/Day/Yr)</i>	Street Address:		
City:	State:	Zip:	Annual Salary:
Social Security No.:	Date Hired:	Employer: ACWA Joint Powers Insurance Authority	

Complete for Life, AD&D, and Additional Life coverages only. Give full name, address, and relationship of your beneficiary.

Examples:

- A. One Beneficiary Dorothy Q. Smith, 777 America St., Anytown, USA 77777, Wife *(not Mrs. John Smith)*
- B. Two Beneficiaries Peter Smith, Father, and Anna Smith, Mother, equally or the survivor
- C. Two Beneficiaries in Unequal Shares Peter Smith, Father, three-fourths (3/4), and Anna Smith, Mother, one-fourth (1/4), or the survivor
- D. One Primary and One Contingent Beneficiary Dorothy Q. Smith, Wife, if living; otherwise Quincy Smith, Son
- E. One Primary and Two Contingent Beneficiaries Dorothy Q. Smith, Wife, if living; otherwise Quincy Smith, Son, and Mary Smith, Daughter, equally, or the survivor.
- F. Trustee Dorothy Q. Smith, Trustee under trust agreement dated _____.
- G. Insured's Estate My Estate

Do you know that if death occurs and a minor (a person not of legal age) or the insured's estate is the beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.

Beneficiary – Complete for Life and AD&D Insurance
Full Name, Address and Social Security #

Relationship

I apply for Insurance under the Group Insurance Plan. I authorize deductions from my wages to cover my contribution, if required, toward the cost of my insurance.

X _____ Date: _____

Note: Beneficiary designation is not valid unless this card is signed and dated.