

ENROLLMENT FORM FOR  
**Group Accidental Death & Dismemberment Insurance**  
 For Virginia Residents

The United States Life Insurance Company in the City of New York  
 Home Office: 70 Pine Street, New York, New York 10270  
 (Herein called the Company)



**STEP 1: Personal Information**

**Member Information**

\_\_\_\_\_  Male  Female

Name (First, Middle, Last)

\_\_\_\_\_

Address

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate (mm/dd/yyyy) \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Place of Birth \_\_\_\_\_ NYSSCPA Member ID Number \_\_\_\_\_

Beneficiary (You are the beneficiary in the event of death of your spouse.) \_\_\_\_\_ Relationship to You \_\_\_\_\_

**Spouse Information (if applying)**

\_\_\_\_\_  Male  Female

Name (First, Middle, Last)

\_\_\_\_\_

Address

\_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birthdate (mm/dd/yyyy) \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_

Phone \_\_\_\_\_ Email Address \_\_\_\_\_

**STEP 2: Select Your Coverage Amount**

Member		Spouse (may not exceed Member's)	
<input type="radio"/> 50,000	<input type="radio"/> 300,000	<input type="radio"/> Not applying	
<input type="radio"/> 100,000	<input type="radio"/> 350,000	<input type="radio"/> 50,000	<input type="radio"/> 300,000
<input type="radio"/> 150,000	<input type="radio"/> 400,000	<input type="radio"/> 100,000	<input type="radio"/> 350,000
<input type="radio"/> 200,000	<input type="radio"/> 450,000	<input type="radio"/> 150,000	<input type="radio"/> 400,000
<input type="radio"/> 250,000	<input type="radio"/> 500,000	<input type="radio"/> 200,000	<input type="radio"/> 450,000
		<input type="radio"/> 250,000	<input type="radio"/> 500,000

**STEP 3: Select Your Billing Preference**

**Billing Selection**

**I prefer to pay:**

Automatic Monthly Withdrawal  Annual Direct Bill

By selecting automatic check withdrawal, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Remember to include a check for your first month's premium and a blank voided check with your application.**

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

I request and authorize withdrawals or charges against my account based on my selected payment method specified above, and such financial institution to process these withdrawals/charges as if I had signed them, for the purpose of collecting premium contributions due for the coverage listed above. I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage immediately if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

Signature of Premium Payer: \_\_\_\_\_

Date: \_\_\_\_\_

**STEP 4: Authorization**

**Authorization**

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under this Accidental Death and Dismemberment Plan. I have read and understand the conditions and exclusions of the program.

I understand that the insurance shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first premium payment.

**Important Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (if applying)