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MOAA GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE ENROLLMENT FORM

Don't send money now! You'll be billed later.

Request for Group Insurance from New York Life Insurance Company,
51 Madison Avenue, New York, NY 10010
Complete this form and return to:
MOAA Insurance Plans • P.O. Box 14464 • Des Moines, IA 50306
Questions? Call Toll-Free **1-800-247-2192**
(Hearing-impaired or voice-impaired members may call the Relay Line at 711-800-247-2192.)
Or, email moaa.service@mercer.com

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS.
INITIAL AND DATE ANY CHANGES YOU MAKE.

1 *Member information*

Member Name: _____
First Middle Last

Address: _____

City: _____

State: _____ ZIP: _____

Home Phone: _____ Date of Birth: _____
mo / day / yr

Work Phone: _____ Membership #: _____

Email Address: _____ Rank/Service: _____
(MOAA Insurance Plans Administrator will not share your email information.)

2 *Benefit Level*

$500,000	☐ Member & Family (N0K3)	☐ Member Only (N0K1)
$250,000	☐ Member & Family (N0E3)	☐ Member Only (N0E1)
$200,000	☐ Member & Family (N0D3)	☐ Member Only (N0D1)
$150,000	☐ Member & Family (N0C3)	☐ Member Only (N0C1)
$100,000	☐ Member & Family (N0B3)	☐ Member Only (N0B1)
$_____Other	☐ Member & Family (N0_3)	☐ Member Only (N0_1)

NOTE: If you select family coverage, the benefit amounts for your spouse and children are based on your family status. Please see the website/enclosed brochure for details.

Premium will be charged on an annual basis. After the first billing, you may choose Electronic Funds Transfer (EFT) as a secure payment option.

3 *Beneficiary*

The death benefit will be paid to the executor or administrator of the owner's estate, or at the option of New York Life, paid in the following order of survival: Spouse, children equally, parents equally, brothers and sisters equally. The member is the beneficiary for any dependent coverage. An alternate beneficiary(ies) can be designated by contacting MOAA Insurance Plans at 1-800-247-2192.

4 *Please read, sign and date*

I hereby enroll with New York Life Insurance Company of New York, New York, for coverage under the MOAA Accidental Death and Dismemberment Plan. I have read and understand the conditions and exclusions of the program. I understand my coverage will become effective upon the first day of the month following the administrator's receipt of this enrollment form and my premium payment.

Member's Signature X _____ **Date X** _____
(Please Sign and Date in ink)

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