

**REMOVE THIS PAGE AND RETURN TO: AMERICAN POSTAL WORKERS
ACCIDENT BENEFIT ASSOCIATION, P.O. BOX 120, ROCHESTER, NH 03866**

ABA PLUS APPLICATION FOR MEMBERSHIP

Member's Full Name: _____ Social Security #: _____

Member's Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ APWU Local: _____

(PLEASE CHECK ONE)

Yes, I would like to increase my ABA Accidental Death Benefit to **\$50,000** at a cost of only \$.75 per pay period. I understand this will be added to my current ABA dues withholding.

Yes, I would like to increase my ABA Accidental Death Benefit to **\$75,000** at a cost of only \$1.13 per pay period. I understand this will be added to my current ABA dues withholding.

Yes, I would like to increase my ABA Accidental Death Benefit to **\$100,000** at a cost of only \$1.50 per pay period. I understand this will be added to my current ABA dues withholding.

Member's Signature

Date: _____

COMPLETE THIS SECTION TO ENROLL YOUR SPOUSE: (Note: Spouse applying for ABA Plus must be a member of the ABA. If your spouse is not an ABA member, contact our office for an application.)

Spouse's Full Name: _____ Date of Birth: _____

Social Security #: _____

Yes, I would like to increase my spouse's ABA Accidental Death Benefit to **\$50,000** at a cost of \$.75 per pay period. I understand this will be added to my current ABA dues withholding.

Group Accidental Death & Dismemberment Insurance is underwritten by
Sun Life And Health Insurance Company
175 Addison Rd., Windsor, CT 06095

EFFECTIVE DATE OF COVERAGE: Coverage is effective the first day ABA Plus assessments are received in our office. An ABA Plus Certificate will be sent to you advising you of your effective date.

BENEFICIARY NOTE: Your ABA Plus beneficiary must match your original ABA beneficiary. Your beneficiary will be noted on your ABA Plus Certificate with instructions on changing your beneficiary if necessary.