

SPOUSE ENROLLMENT FORM

Office Hours Monday-Friday
8:00 am – 4:00 pm est

AMERICAN POSTAL WORKERS
ACCIDENT BENEFIT ASSOCIATION
Post Office Box 120
Rochester, NH 03866
(603) 330-0282

**YOUR NON-PROFIT
BENEFIT PLAN**

I, being a member of the Accident Benefit Association hereby authorize the following:
(Check one option only)

1. Value Plan for my spouse. (Dues withholding adjusted accordingly).
2. Advantage Plan for my spouse. (Dues withholding adjusted accordingly).

MEMBER INFORMATION

(PLEASE PRINT)

Member Name _____ s.s.# _____

Address _____

City _____ State _____ Zip Code _____

Member Signature _____ Date _____

SPOUSE INFORMATION

Spouse Name _____ s.s.# _____

Date of Birth ___ / ___ / ___

Spouse Beneficiary _____

Relationship to Spouse _____

Spouse Signature _____ Date _____