ARCHDIOCESE of NEW YORK

GROUP NON-CONTRIBUTORY BASIC LIFE
ENROLLMENT AND CHANGE FORM

Please print clearly and be sure to sign and date this form. Return your completed form to your employer's office.

( ) I want to be covered under the group plan benefits for which I am eligible. *(Initial enrollment)*
( ) Update: Change of beneficiary

Your Name: _____

Home Address: _____

Social Security Number: _____

Date of Birth:_____ Sex: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Home Phone:_____ Work Phone:_____

Name of Employer:_____

Employer's Address:_____

Occupation:_____

Institution #:_____ Division #::_____ If this is a transfer, give old institution/Division #:_____

Salary:$_____ Date of Hire:_____ Effective Date:_____

Designation of Beneficiary

( ) **I designate as my beneficiary(ies)**:

Name:_____

Address:_____

DOB: _____SSN:_____Relationship:_____Percentage:_____

Name: _____

Address: _____

DOB: _____SSN:_____Relationship:_____Percentage:_____

If the beneficiary dies before me, I designate as contingent beneficiary:

Name:_____

Address: _____

DOB: _____SSN:_____Relationship:_____Percentage: _____

- If there is more than one beneficiary or more than one contingent beneficiary, they will share the death benefits equally, or all will be paid to the survivor.
- I RESERVE the right to change this designation at any time.

Employee's Signature:_____ Date:_____

ADMINISTRATORS, Email or fax a copy of this form together with a copy of the medical enrollment form to Employee Benefit Connections, fax number: 212 644-0690 or email to ebc@archny.org

For additional beneficiaries, please attach a separate list and include the names, addresses, dates of births and relationship to the employee