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Patrolmen's Benevolent Association of the City of New York, Inc.

ASSOCIATE MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

Eligibility	All Associate members of the Patrolmen's Benevolent Association of the City of New York, Inc.
Date Your Optional Term Life Insurance Coverage Starts	Coverage will begin once the enrollment form has been processed.
Optional Term Life Insurance Benefit Options	You: An amount equal to $5,000, $30,000 or $60,000. You must elect coverage in order for spouse or child to be eligible for coverage. Your Spouse: $12,000 Your Child(ren): $3,000 (from age live birth to age 19, or 25 if full-time student, unmarried and dependent upon you for support).

Optional Term Life Insurance Monthly Premiums

Member: $0.20 per $1,000 Spouse & Child(ren): $1.06 per family unit

Guaranteed Issue Amount	The guaranteed issue amount is the amount of insurance that eligible members may elect *without providing evidence of good health.* Timely Applicants: *You* may elect up $60,000. You may elect dependent *spouse* coverage of $12,000; and $3,000 for dependent child(ren). Late Applicant: *(did not enroll within 31 days of eligibility)* For *You* and your *Spouse*, evidence of good health is required for any requested coverage amount. For your *child(ren)*, you can elect coverage of $3,000. Evidence of good health is not required.
Evidence of Good Health	You will need to provide evidence of good health for review and approval by Aetna's underwriters in the following situations: ▪ If you do not enroll during the later of 31 days from the date of your promotion or receipt of notice via mail.
Age Reductions	None
Optional Life Benefit Features	Conversion If you terminate employment, are no longer eligible for coverage, or your coverage reduces due to age, pension or retirement, you have the opportunity to convert your group coverage to an individual whole life insurance policy within 31 days of your termination in coverage.

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Patrolmen's Benevolent Association of the City of New York, Inc.

ASSOCIATE MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

Aetna Life Essentials	You now have access to benefits and resources that can help you make the most of every stage of your life. Your life insurance includes new features that help you live fully today and better prepare for tomorrow.
	
	Caring support and resources
	We'll help by providing emotional and financial support during end of life – for you, your family and caregivers.
	
	• Resources when they are needed most – If you or your covered spouse becomes terminally ill, you can get up to 50% of your life insurance benefit amount ahead of time to a max of $500,000, based on your plan. You can receive these benefits if your doctors determine your life expectancy will likely not exceed 6 months. You can use the money to pay medical and other bills during an illness to help preserve your life savings.
	
	• Financial Planning Services+ – Through an arrangement with JP Morgan Chase*, active members, retirees and beneficiaries of deceased life members have access to certain financial planning services and advice at no additional cost to you.
	
	• Legal Services+ – Through the Legal Reference®**+ Program members and their spouses have access to certain on-line estate planning services. On-line services available include:
	  • Living wills
	  • Health care directives
	  • Durable financial power of attorney
	  • Basic will preparation services (two annually)
	Terminally ill life members will have access to several additional estate planning services, delivered in the attorney's office and paid in full:
	  • Will preparation
	  • Health care power of attorney document preparation
	  • Durable financial power of attorney document preparations
	  • Uncontested guardianship documentation
	  • Tax planning preparation
	  • Legal representation for the real estate sale of primary residence
	• Emotional Services+ – We want to help you, not only financially, but emotionally. That's why we provide you, your family members, beneficiaries and caregivers with access to the Compassionate Care Website and bereavement and grief counseling services.
	
	Life Essentials website: www.aetna.com/group/aetna_life_essentials
	
	* Securities (including mutual funds and variable annuities) and investment advisory services are offered through Chase Investment Services Corp, (CISC) or affiliated broker/dealers. Annuities and insurance products are provided by various insurance companies and offered through Chase Insurance Agency, Inc. (CIA), a licensed insurance agency, doing business as Chase Insurance Agency Services, Inc. in Florida. CISC, a member of NASD/SIPC, and CIA are affiliates of JPMorgan Chase Bank, N.A. Products not available in all states. JPMorgan Chase Bank, N.A., and its affiliates do not offer legal or accounting advice to their clients. Clients are urged to consult with their own legal, accounting and tax advisors with respect to their specific situations. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC. NOT A DEPOSIT NOT FDIC INSURED NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY NOT GUARANTEED BY THE BANK MAY GO DOWN IN VALUE **The Legal Reference Program is

This Summary of Benefits explains the general purpose of the insurance described, but in no way changes or affects the policy as it is actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

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Patrolmen's Benevolent Association of the City of New York, Inc.

ASSOCIATE MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

	independently administered by ARAG® Services LLC. Aetna does not participate in attorney selection or review, and does not monitor ARAG services, content (including website content) or network. Aetna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website, the services of ARAG or of any attorney in the ARAG network. Aetna does not credential or otherwise make any representations as to the quality or appropriateness of long-term care providers offering discounts to Aetna members. Life products are underwritten or administered by Aetna Life Insurance Company. [+] This particular Aetna Life Essentials program feature is not insurance, is provided at no additional cost to you, and may be changed or discontinued at any time by Aetna without notice. Additional program limitations and restrictions apply.

This Summary of Benefits explains the general purpose of the insurance described, but in no way changes or affects the policy as it is actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

Life Enrollment/Change Request

Aetna Life Insurance Company

Associate Members

Mail or fax completed form to:

Aetna Benefit Services
480 E. Swedesford Rd., Suite 110
Wayne, PA 19087
Phone: 866-428-8019
Fax: 610-889-9128

Refer to the instructions on Page 3 when completing this form.

A. Plan Sponsor Group Information

Control	Suffix	Account	Plan Number
838996	25	000	SB

Full Name of Business or Organization	SFO	Claim Office
PATROLMEN'S BENEVOLENT ASSOCIATION OF THE CITY OF NEW YORK, INC.	138	174
Address (Street, City, State, ZIP Code)[- Primary Location of Business or Organization **125 BROAD STREET, 11TH FLOOR, NEW YORK, NY 10004**		

B. Member Information - Please Print all Information

Member Social Security Number	Member Name (Last, First, M.I.)		
Member Home Address (Number, Street, Apt. No., City, State, ZIP Code)		Birthdate (MM/DD/YYYY) / /	Sex ☐ Male ☐ Female
Telephone Number Home ( ) Cell ( ) -	Occupation/Title		

C. Declination/Waiver of Coverage - To be completed if coverage is declined or refused by Member

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll.	*Please sign here ONLY IF YOU ARE DECLINING coverage.* **Member Signature X** _____ **Date** _____

D. Enrollment/Change Information

1. Enrollment - *Check one.*

- ☐ New Member
- ☐ Rehire/Reinstatement
- ☐ Late Applicant
- ☐ Retiree

Effective Date (MM/DD/YYYY) _____

Date of Rehire (MM/DD/YYYY) _____

☐ Check here if enrollment is due to a Family Status change.

2. Change applies to:

- ☐ Member
- ☐ Spouse
- ☐ Child(ren)

Effective Date (MM/DD/YYYY) _____

☐ Check here if change is due to a Family Status change.

E. Member Plan Options and Coverage Amounts

Based on the requirements of your Plan, you may be required to submit evidence of good health.

1. Member must be enrolled for member coverage in order to enroll spouse/child(ren) for coverage.

☐ Enroll ☐ Change Plan ☐ Increase ☐ Decrease
☐ Cancel ☐ Terminate ☐ Other Changes (Provide details in Section **G**, Special Remarks)

2.

Optional Life Election for Member:
(Please check box with your election)

- ☐ **$5,000** Life Benefit = $1.00 per member per month
- ☐ **$30,000** Life Benefit = $6.00 per member per month
- ☐ **$60,000** Life Benefit = $12.00 per member per month

3. Beneficiary Designation (Life Insurance ONLY) Spouse and Child(ren) coverage: Beneficiary is always the Member

If additional beneficiaries, use Section G - Special Remarks. *** If naming more than one beneficiary, percentages must equal 100%.**

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Member	% of Benefit *
☒ Primary			
☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			

F. Spouse Plan Options and Coverage Amounts - Please Print all Information. ☐ Check this box if you are not electing dependent coverage.

Based on the requirements of your Plan, your dependent spouse may be required to submit evidence of good health.

1. Dependent Spouse - Name (Last, First, M.I.)	Relation. Code	Sex M ☐ F ☐	Birthdate (MM/DD/YYYY)	Social Security Number
			/ /	

2. Member must be enrolled for Member coverage in order to enroll dependent for coverage.

☐ Enroll ☐ Change Plan ☐ Increase ☐ Decrease

☐ Cancel ☐ Other Changes (Provide details in Section **H**, Special Remarks.)

3.

☐ Optional Life Election for Dependent Spouse, Dependent Children or both Dependent Spouse and Dependent Children

Life Benefit is: **$12,000 for spouse; $3,000 per child**

Monthly Rate = $1.06 per Family unit (includes spouse and child(ren).
Please check box if enrolling dependents.

G. Special Remarks - Use this space to provide clarification and/or additional information for Sections **E** through **F**. *Please Print Clearly*

H. Certification - Signature Required *Member's E-mail Address:*

My signature below signifies my agreement with the statements and authorization in the **Certification and Authorization** section and the **Misrepresentation** section on Page 3 of this form.

Member Signature (Required)	Date
X	

Please make a copy for your records. **Visit us at www.mybenefitharbor.com/ees/pba**

Certification and Authorization

1. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided to me and the certificate issued to me.
2. I understand that the effective date of insurance for me or for any of my dependents is subject to the health condition requirements of the Plan when needed. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my eligibility as well as my dependent's eligibility, may be affected.
4. I request my Plan Sponsor to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my pension or Aetna may bill me directly.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and subjects such person to criminal and civil penalties.

INSTRUCTIONS

Section A – Plan Sponsor Group Information

- If not preprinted, provide the complete Control, Suffix, Account Number and Plan Number.
- If not preprinted, provide Plan Sponsor's name and address.

Section B – Member Information

- Complete **all** information requested. Incomplete or missing information may result in delays in the processing of your Enrollment/Change Request.
- Birthdate should include four-digit year of birth.

Section C - Declination of Coverage

- If you are waiving coverage complete only Sections A, B and C.
- **Note:** Your Plan Sponsor's plan may require the Member to be enrolled for Member coverage in order to enroll your spouse/child(ren) for coverage. If this requirement is part of your Plan Sponsor's plan, the Enrollment/Change Request form will state this in Sections E1 and F2.

Section D - Enrollment/Change Information

- Check all applicable boxes in Section D1.
- Complete the Effective Date and Date of Rehire.
- If you are making a change, check all applicable boxes and complete the effective date in Section D2.

Section E – Member Plan Options and Coverage Amounts

- Check the box applicable to the action you are initiating in Section E1.
- Check the box(es) applicable to the benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section E2.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.
- Complete the Beneficiary Designation in Section E3 only if your Plan Sponsor's plan includes a Life Insurance benefit and you are electing this Life Insurance benefit.
  - Provide the full legal name of your beneficiary(ies), Social Security Number, relationship to the Member and the percentage of your benefit that will be paid to the designated beneficiary(ies) in the event of your death. Dollars and cents should not be specified. When added together, the sum of the percentages going to two or more named beneficiaries should not be more or less than 100%. Contingent beneficiary(ies) will only receive proceeds if all primary beneficiaries have predeceased the Member.

Section F - Spouse Plan Options and Coverage Amounts

- If enrolling/changing spousal coverage, provide the full name of your spouse and all other information requested in Section F1.
  - **Relationship Code** - Select one: H=Husband, W=Wife, Y=Sponsored Male, X=Sponsored Female.
  - Birthdate should include four-digit year of birth.
- Check the box applicable to the action you are initiating in Section F2.
- Check the box(es) applicable to the spousal benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section F3.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.

Section G - Special Remarks

- Use this space to provide clarification and/or additional information if needed.
- Please note: additional information provided by Aetna or your Plan Sponsor may appear in this space.

Section I - Certification (Signature Required)

- Read the **Certification and Authorization** section and the **Misrepresentation** section on Page 2 prior to signing the form.
- **Sign, date the form and mail or fax (see mailing and fax number on top of page 1)**
- Please make a copy of this form for your records.

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Patrolmen's Benevolent Association of the City of New York, Inc.

RETIRED & SEPARATED MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

Eligibility	All Members of the Patrolmen's Benevolent Association in good standing, age 64 or less, who attain retirement/separated status.
Date Your Optional Term Life Insurance Coverage Starts	Coverage will begin once the enrollment form has been processed.
Optional Term Life Insurance Benefit Options	You: An amount equal to $12,500, $30,000 or $60,000. You must elect coverage in order for spouse or child to be eligible for coverage. Your Spouse: $5,000 Your Child(ren): $1,000 (from age live birth to age 19, or 25 if full-time student, unmarried and dependent upon you for support).

Optional Term Life Insurance Monthly Premiums
Member per $1,000 of coverage:

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Rate for Member	$0.080	$0.096	$0.129	$0.145	$0.161	$0.241	$0.370	$0.692	$1.062

Spouse & Child(ren): $1.06 Per Family Unit

Rates will increase as you move from one age band to the next. Refer to above rate chart for increase schedule.

Guaranteed Issue Amount	The guaranteed issue amount is the amount of insurance that eligible members may elect *without providing evidence of good health.* Timely Applicants: *You* may elect up $60,000. You may elect dependent *spouse* coverage of $5,000; and $1,000 for dependent child(ren). Late Applicant: *(did not enroll within 31 days of eligibility)* For *You* and your *Spouse*, evidence of good health is required for any requested coverage amount. For your *child(ren)*, you can elect coverage of $1,000. Evidence of good health is not required.
Evidence of Good Health	You will need to provide evidence of good health for review and approval by Aetna's underwriters in the following situations: ▪ If you do not enroll during the later of 31 days from the date of your retirement/separation or receipt of notice via mail.
Age Reductions	None

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Patrolmen's Benevolent Association of the City of New York, Inc.

RETIRED & SEPARATED MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

Optional Life Benefit Features	Conversion If you terminate employment, are no longer eligible for coverage, or your coverage reduces due to age, pension or retirement, you have the opportunity to convert your group coverage to an individual whole life insurance policy within 31 days of your termination in coverage.

Aetna Life Essentials	You now have access to benefits and resources that can help you make the most of every stage of your life. Your life insurance includes new features that help you live fully today and better prepare for tomorrow.
	
	Caring support and resources
	We'll help by providing emotional and financial support during end of life – for you, your family and caregivers.
	
	• Resources when they are needed most – If you or your covered spouse becomes terminally ill, you can get up to 50% of your life insurance benefit amount ahead of time to a max of $500,000, based on your plan. You can receive these benefits if your doctors determine your life expectancy will likely not exceed 6 months. You can use the money to pay medical and other bills during an illness to help preserve your life savings.
	
	• Financial Planning Services+ – Through an arrangement with JP Morgan Chase*, active members, retirees and beneficiaries of deceased life members have access to certain financial planning services and advice at no additional cost to you.
	
	• Legal Services+ – Through the Legal Reference®**+ Program members and their spouses have access to certain on-line estate planning services. On-line services available include:
	  • Living wills
	  • Health care directives
	  • Durable financial power of attorney
	  • Basic will preparation services (two annually)
	  •
	Terminally ill life members will have access to several additional estate planning services, delivered in the attorney's office and paid in full:
	  • Will preparation
	  • Health care power of attorney document preparation
	  • Durable financial power of attorney document preparations
	  • Uncontested guardianship documentation
	  • Tax planning preparation
	  • Legal representation for the real estate sale of primary residence
	
	• Emotional Services+ – We want to help you, not only financially, but emotionally. That's why we provide you, your family members, beneficiaries and caregivers with access to the Compassionate Care Website and bereavement and grief counseling services.
	
	Life Essentials website: www.aetna.com/group/aetna_life_essentials

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Patrolmen's Benevolent Association of the City of New York, Inc.

RETIRED & SEPARATED MEMBERS
OPTIONAL TERM LIFE & DEPENDENT TERM LIFE
SUMMARY OF BENEFITS

* Securities (including mutual funds and variable annuities) and investment advisory services are offered through Chase Investment Services Corp, (CISC) or affiliated broker/dealers. Annuities and insurance products are provided by various insurance companies and offered through Chase Insurance Agency, Inc. (CIA), a licensed insurance agency, doing business as Chase Insurance Agency Services, Inc. in Florida. CISC, a member of NASD/SIPC, and CIA are affiliates of JPMorgan Chase Bank, N.A. Products not available in all states. JPMorgan Chase Bank, N.A., and its affiliates do not offer legal or accounting advice to their clients. Clients are urged to consult with their own legal, accounting and tax advisors with respect to their specific situations. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC. NOT A DEPOSIT NOT FDIC INSURED NOT INSURED BY ANY FEDERAL GOVERNMENT AGENCY NOT GUARANTEED BY THE BANK MAY GO DOWN IN VALUE **The Legal Reference Program is independently administered by ARAG® Services LLC. Aetna does not participate in attorney selection or review, and does not monitor ARAG services, content (including website content) or network. Aetna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website, the services of ARAG or of any attorney in the ARAG network. Aetna does not credential or otherwise make any representations as to the quality or appropriateness of long-term care providers offering discounts to Aetna members. Life products are underwritten or administered by Aetna Life Insurance Company.

+ This particular Aetna Life Essentials program feature is not insurance, is provided at no additional cost to you, and may be changed or discontinued at any time by Aetna without notice. Additional program limitations and restrictions apply.

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Life Enrollment/Change Request

Aetna Life Insurance Company

Retired & Separated Members

Mail or fax completed form to:

Aetna Benefit Services
480 E. Swedesford Rd., Suite 110
Wayne, PA 19087
Phone: 866-428-8019
Fax: 610-889-9128

Refer to the instructions on Page 3 when completing this form.

A. Plan Sponsor Group Information

Control	Suffix	Account	Plan Number
838996	27	000	RB

Full Name of Business or Organization	SFO	Claim Office
PATROLMEN'S BENEVOLENT ASSOCIATION OF THE CITY OF NEW YORK, INC.	138	174
Address (Street, City, State, ZIP Code)[- Primary Location of Business or Organization **125 BROAD STREET, 11TH FLOOR, NEW YORK, NY 10004**		

B. Member Information - Please Print all Information

Member Social Security Number	Member Name (Last, First, M.I.)		
Member Home Address (Number, Street, **Apt. No.,** City, State, ZIP Code)		Birthdate (MM/DD/YYYY) / /	Sex ☐ Male ☐ Female
Telephone Number Home ( ) Cell ( ) -	Occupation/Title		

C. Declination/Waiver of Coverage - To be completed if coverage is declined or refused by Member

I acknowledge I have been given the right to apply for this coverage; however, I am electing not to enroll.	*Please sign here ONLY IF YOU ARE DECLINING coverage.* **Member Signature X** _____ **Date** _____

D. Enrollment/Change Information

1. Enrollment - *Check one.*

- ☐ New Member
- ☐ Rehire/Reinstatement
- ☐ Late Applicant
- ☐ Retiree

Effective Date (MM/DD/YYYY) _____

Date of Rehire (MM/DD/YYYY) _____

☐ Check here if enrollment is due to a Family Status change.

2. Change applies to:

- ☐ Member
- ☐ Spouse
- ☐ Child(ren)

Effective Date (MM/DD/YYYY) _____

☐ Check here if change is due to a Family Status change.

E. Member Plan Options and Coverage Amounts

Based on the requirements of your Plan, you may be required to submit evidence of good health.

1. Member must be enrolled for member coverage in order to enroll spouse/child(ren) for coverage.

☐ Enroll ☐ Change Plan ☐ Increase ☐ Decrease
☐ Cancel ☐ Terminate ☐ Other Changes (Provide details in Section **G**, Special Remarks)

2.

☐ Optional Life Election for Member: $_____

Choose from a benefit of: $12,500, $30,000 or $60,000 (Monthly rates below)

Member's Age	$12,500	$30,000	$60,000
Under 25	$1.00	$2.40	$4.80
25-29	$1.20	$2.88	$5.76
30-34	$1.61	$3.87	$7.74
35-39	$1.81	$4.35	$8.70
40-44	$2.01	$4.83	$9.66
45-49	$3.01	$7.23	$14.46
50-54	$4.63	$11.10	$22.20
55-59	$8.65	$20.76	$41.52
60-64	$13.28	$31.86	$63.72

3. Beneficiary Designation (Life Insurance ONLY) Spouse and Child(ren) coverage: Beneficiary is always the Member

If additional beneficiaries, use Section G - Special Remarks. *** If naming more than one beneficiary, percentages must equal 100%.**

Full Beneficiary Name (First, Middle, Last)	Social Security Number of Beneficiary	Relationship to Member	% of Benefit *
☒ Primary			
☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			
☐ Primary ☐ Contingent			

F. Spouse Plan Options and Coverage Amounts - Please Print all Information. ☐ Check this box if you are not electing dependent coverage.

Based on the requirements of your Plan, your dependent spouse may be required to submit evidence of good health.

1. Dependent Spouse - Name (Last, First, M.I.)	Relation. Code	Sex M ☐ F ☐	Birthdate (MM/DD/YYYY)	Social Security Number
			/ /	

2. Member must be enrolled for Member coverage in order to enroll dependent for coverage.

☐ Enroll ☐ Change Plan ☐ Increase ☐ Decrease

☐ Cancel ☐ Other Changes (Provide details in Section **H**, Special Remarks.)

3.

☐ Optional Life Election for Dependent Spouse, Dependent Children or both Dependent Spouse and Dependent Children

Life Benefit is: **$5,000 for spouse; $1,000 per child**

Monthly Rate = $1.06 per Family unit (includes spouse and child(ren).
Please check box if enrolling dependents.

G. Special Remarks - Use this space to provide clarification and/or additional information for Sections **E** through **F**. *Please Print Clearly*

H. Certification - Signature Required *Member's E-mail Address:*

My signature below signifies my agreement with the statements and authorization in the **Certification and Authorization** section and the **Misrepresentation** section on Page 2 of this form.

Member Signature (Required)	Date
X	

Please make a copy for your records. **Visit us at www.mybenefitharbor.com/ees/pba**

Certification and Authorization

1. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided to me and the certificate issued to me.
2. I understand that the effective date of insurance for me or for any of my dependents is subject to the health condition requirements of the Plan when needed. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent.
3. I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my eligibility as well as my dependent's eligibility, may be affected.
4. I request my Plan Sponsor to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my pension or Aetna may bill me directly.

Misrepresentation

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and subjects such person to criminal and civil penalties.

INSTRUCTIONS

Section A – Plan Sponsor Group Information

- If not preprinted, provide the complete Control, Suffix, Account Number and Plan Number.
- If not preprinted, provide Plan Sponsor's name and address.

Section B – Member Information

- Complete **all** information requested. Incomplete or missing information may result in delays in the processing of your Enrollment/Change Request.
- Birthdate should include four-digit year of birth.

Section C - Declination of Coverage

- If you are waiving coverage complete only Sections A, B and C.
- **Note:** Your Plan Sponsor's plan may require the Member to be enrolled for Member coverage in order to enroll your spouse/child(ren) for coverage. If this requirement is part of your Plan Sponsor's plan, the Enrollment/Change Request form will state this in Sections E1 and F2.

Section D - Enrollment/Change Information

- Check all applicable boxes in Section D1.
- Complete the Effective Date and Date of Rehire.
- If you are making a change, check all applicable boxes and complete the effective date in Section D2.

Section E – Member Plan Options and Coverage Amounts

- Check the box applicable to the action you are initiating in Section E1.
- Check the box(es) applicable to the benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section E2.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.
- Complete the Beneficiary Designation in Section E3 only if your Plan Sponsor's plan includes a Life Insurance benefit and you are electing this Life Insurance benefit.
  - Provide the full legal name of your beneficiary(ies), Social Security Number, relationship to the Member and the percentage of your benefit that will be paid to the designated beneficiary(ies) in the event of your death. Dollars and cents should not be specified. When added together, the sum of the percentages going to two or more named beneficiaries should not be more or less than 100%. Contingent beneficiary(ies) will only receive proceeds if all primary beneficiaries have predeceased the Member.

Section F - Spouse Plan Options and Coverage Amounts

- If enrolling/changing spousal coverage, provide the full name of your spouse and all other information requested in Section F1.
  - **Relationship Code** - Select one: H=Husband, W=Wife, Y=Sponsored Male, X=Sponsored Female.
  - Birthdate should include four-digit year of birth.
- Check the box applicable to the action you are initiating in Section F2.
- Check the box(es) applicable to the spousal benefit(s) you wish to enroll/change and provide the coverage amount you are requesting in Section F3.
  - **Note:** Evidence of Good Health may be required. Please refer to your plan documents for details.

Section G - Special Remarks

- Use this space to provide clarification and/or additional information if needed.
- Please note: additional information provided by Aetna or your Plan Sponsor may appear in this space.

Section I - Certification (Signature Required)

- Read the **Certification and Authorization** section and the **Misrepresentation** section on Page 3 prior to signing the form.
- **Sign, date the form and mail or fax (see mailing and fax number on top of page 1)**
- Please make a copy of this form for your records.