

**To Be Completed By Plan Administrator**

Group Number <b>641419</b>	Group Name <b>Association of California School Administrators (ACSA)</b>	Membership Date	Effective Date
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**To Be Completed By Applicant**

Additional forms and electronic authorization forms are available from the plan administrator, Keenan & Associates. Please mail completed and signed enrollment forms to the address below.

Keenan & Associates - Dept 25, PO Box 981044, Boston, MA 02298-1044, Phone: 424.285.8086 ext. 340103

- Apply for Coverage    New Member of Association (previously never eligible)  
 Add Dependent    Delete Dependent   Date of Add/Delete \_\_\_\_\_  
 Beneficiary Change **Complete Beneficiary Section.**    Name Change   Former Name \_\_\_\_\_

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Email Address	Home Phone Number	Work Phone Number		
Job Title/Occupation	Earnings \$ _____ Per Year	Hours Worked Per Week	Are You Actively At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Check with your plan administrator about coverage options, minimum and maximums available to you.

**Voluntary Accidental Death and Dismemberment Insurance****For You**

- Voluntary AD&D requested coverage amount \$ \_\_\_\_\_

**For Your Family**

- Dependents AD&D requested

Spouse Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**Beneficiary Information**

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Return completed form to Keenan & Associates.

**Beneficiary**

*This designation applies to your Accidental Death and Dismemberment Insurance, if any, available through your association, unless replaced by a separate and later designation. Designations are not valid unless signed, dated and delivered in accordance with the terms of the Group Policy during your lifetime.*

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. if known	Relationship	% of Benefit*

  

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. if known	Relationship	% of Benefit*

**\*Total must equal 100%**

**Signature**

- I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction will change if my coverage or costs change.
- I wish to make the choices indicated on this form. If electing coverage, I wish to authorize electronic payment (credit card or ACH) to cover my contribution toward the cost of insurance. I understand that my deduction will change if my coverage or costs change.

Member/Employee Signature Required \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_

**Return completed form to Keenan & Associates.**