



If you are currently enrolled in the Union's Dental/Vision Insurance, or the Union's Voluntary Life Insurance, and wish to cancel or de-enroll from it, fill out the enclosed documentation and return to the Union Office one of three ways:

- 1. Deliver in person to the Union Office**
- 2. Fax to the Union Hall at (901) 386-3105**
- 3. Mail to the Union Office at 5150 Stage Rd, Suite 103, Memphis, TN 38134**

This must be received no later than November 30, 2020. No exceptions.

Questions can be directed to the Union Office at (901) 386-3129.



DENTAL/VISION INSURANCE ELECTION FORM

_____ I wish to enroll in the dental/vision insurance from IAFF Local 1784
(Please fill out the enclosed enrollment form and payroll deduction form)

_____ I wish to de-enroll from the dental/vision insurance from IAFF Local 1784
(Please fill out the enclosed CANCEL form)

Member's Signature

Date



_____ I wish to purchase the voluntary life insurance on myself (this is in addition to the \$10,000 insurance the union provides to me as a part of my membership)

_____ I choose the \$20,000 life insurance on myself (\$3.25 per pay period)

_____ I choose the \$50,000 life insurance on myself (\$8.13 per pay period)

_____ I choose to decline the voluntary life insurance on myself at this time. I understand I can enroll at a later time during open enrollment.

_____ I wish to purchase life insurance on my spouse (**the voluntary life insurance on yourself must be selected in order to enroll in the spousal and/or child life insurance**)

_____ I choose the \$10,000 coverage on my spouse (\$1.25 per pay period)

_____ I choose the \$25,000 coverage on my spouse (\$3.13 per pay period)

Spouse's Name

Spouse's Social Security Number

Spouse's Date of Birth

_____ I choose to decline the life insurance on my spouse at this time. I understand I can enroll at a later time during open enrollment.

_____ I choose to purchase life insurance on my child(ren) (**the voluntary life insurance on yourself must be selected in order to enroll in the child and/or spousal life insurance**)

Child's Name

Child's Social Security Number

Child's Date of Birth

_____ I choose to decline the life insurance on my child(ren) at this time. I understand I can enroll at a later time during open enrollment.

Member's Signature

Date

*******CANCEL DEDUCTIONS*******

Memphis Fire Fighters Association, IAFF Local 1784

I, the undersigned, hereby wish to cancel the following deductions effective immediately. I understand that by canceling said deductions, I lose coverage(s) associated with the deductions. I understand that it may take up to thirty (30) days for these deductions to take effect.

Please Print Name

Last

First

Middle Initial

Address

Number/Street

City

Zip

Telephone

Dept. – Fire Division 13 (or Fire Retiree)

Employee ID # (SSN# for Retirees)

All Amounts Listed Are Per Pay Period

(Please fill in the amounts in order to **CANCEL**)

A. Dental Insurance

Employee Only..... \$ _____

Employee + 1..... \$ _____

Family..... \$ _____

B. Optional Life Insurance (NCPERS)..... \$ _____

C. Optional Life Insurance (Aetna \$20,000 voluntary life)..... \$ _____

Optional Life Insurance (Aetna \$50,000 voluntary life)..... \$ _____

D. Optional Life Insurance (Aetna Child/Spousal Coverage).....\$ _____

Signature _____ **Date** _____



**Memphis Fire Fighters Association
IAFF Local 1784
Life Insurance Beneficiary Form**

Name: _____ Employee ID #: _____

Address: _____

Email Address (personal, not city): _____

Cell Phone: _____ Last 4 digits of SSN: _____

Date of Birth: _____ FD Work Assignment (or Retired): _____

The sum of all primary beneficiaries must total 100% and the sum of any/all contingent beneficiaries must total 100% (e.g. allocation of three primary beneficiaries could be 34%, 33%, 33%).

PRIMARY BENEFICIARY DESIGNATION

Name (Last, First)	Phone Number	Relationship	Date of Birth	Share %

Applies To: _____ Group Life _____ Voluntary Life _____ Both Group Life & Voluntary Life

CONTINGENT BENEFICIARY DESIGNATION

Name (Last, First)	Phone Number	Relationship	Date of Birth	Share %

Applies To: _____ Group Life _____ Voluntary Life _____ Both Group Life & Voluntary Life

Signature: _____ Date: _____