If you are currently enrolled in the Union's Dental/Vision 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

*****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 BENFICIARY DESIGNATION

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

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

CONTINGENT BENFICIARY DESIGNATION

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

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

Signature: _____ Date: _____

3/2019 (MJT)