



# PERSONAL ACCIDENT INSURANCE ENROLLMENT/CHANGE FORM



## CAL FIRE Local 2881

Member's Name: \_\_\_\_\_  
*Last, First, M.I.*

Address: \_\_\_\_\_  
*Street, City, State, Zip*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mm/dd/yyyy*

Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email Address: \_\_\_\_\_

### Check Choice of Plan: (Check Appropriate box(es))

- Member Only** (Class I)     
  **Buy-Up Coverage** (Class II - Optional)     
  **Family Plan** (Class III)

### Check Benefit Amount:

- \$100,000   
  \$200,000   
  \$300,000   
  \$400,000   
  \$500,000   
  Other\$ \_\_\_\_\_  
*Not to exceed \$500,000*

Beneficiary: \_\_\_\_\_ / \_\_\_\_\_  
*Name / Relationship*

*The beneficiary of the spouse and dependent child(ren) will be the insured member unless otherwise requested in writing to the Insurance Company.*

Spouse: \_\_\_\_\_  
*Last, First, M.I.*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Child(ren):

Name: \_\_\_\_\_  
*Last, First, M.I.*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
*Last, First, M.I.*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name: \_\_\_\_\_  
*Last, First, M.I.*

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I acknowledge that I have read, understand, and agree to the terms and conditions of this coverage as detailed in the handout and I authorize the premium deduction from my pay for the insurance applied for as shown above. I understand that if I purchase more than I am allowed, any excess premiums will be refunded.

I have been given the opportunity for this insurance but I **do not desire to participate.**

Member's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requested Effective Date of Coverage (mm/yyyy) \_\_\_\_\_



**AIG Domestic Accident & Health Division**  
*A Division of American International Companies*  
Two Rincorn Center • 121 Spear Street • San Francisco, CA 94105-1588



License 0509203



PERSONAL ACCIDENT INSURANCE  
EXCHANGE FORM



CPA Form 1099

Form with multiple horizontal lines for text entry, including fields for name, address, and contact information.

**Mail to:**

CPF Insurance Trust  
Harry J. Wilson Insurancenter Inc.

P.O. Box 27098  
Fresno, CA 93729-7098

1 (888) 811-0811  
Fax (888) 273-6630

