CHUBB

# 24-Hour Accidental Death & Dismemberment Insurance Enrollment Form

## Applicant Information

Full Name: Date of Birth:

(As it should appear on the Policy)

Street Address:

City: State: Zip Code:

Gender: ☐ Male ☐ Female

Email: Phone:

## Coverage Selection and Premium

Select your desired Accidental Death & Dismemberment (AD&D) benefit amount (left) and who you'd like to be covered on the policy (top).

| | ☐ Member Only | ☐ Member + Spouse | ☐ Member + Child(ren) | ☐ Member + Family |
|---|---|---|---|---|
| **AD&D Benefit** | **Monthly Premium** | **Monthly Premium** | **Monthly Premium** | **Monthly Premium** |
| ☐ $100,000 | $4.50 | $6.30 | $5.40 | $6.75 |
| ☐ $150,000 | $6.75 | $9.45 | $8.10 | $10.13 |
| ☐ $200,000 | $9.00 | $12.60 | $10.80 | $13.50 |
| ☐ $250,000 | $11.25 | $15.75 | $13.50 | $16.88 |
| ☐ $300,000 | $13.50 | $18.90 | $16.20 | $20.25 |
| ☐ $350,000 | $15.75 | $22.05 | $18.90 | $23.63 |
| ☐ $400,000 | $18.00 | $25.20 | $21.60 | $27.00 |
| ☐ $450,000 | $20.25 | $28.35 | $24.30 | $30.38 |
| ☐ $500,000 | $22.50 | $31.50 | $27.00 | $33.75 |

## Beneficiary Information

Full Name: Date of Birth:

Relationship to Applicant:

Check here if the mailing address is the same as the insured ☐

**If not, please provide the beneficiary's mailing address below:**

Street Address:

City: State: Zip Code:

Email:

## Acknowledgment and Signature

I hereby apply for Accidental Death Insurance coverage as indicated above. I understand that coverage is subject to the terms and conditions of the policy. I authorize Chubb to process my application as indicated.

Signature: Date:

## Payroll Deduction Authorization

Name: Social Security Number:

An employee of: Monthly Premium: $

Signature: Date:

I hereby authorize my employer, as my agent, to deduct from my pay the amount indicated above and to apply it in payment on the policy of insurance issued to me by Federal Insurance Company. This is also authorization to make deduction in succeeding years of my employment in the amounts required to keep my insurance in force under such policy. Deductions shall cease upon termination of my employment, or at any time upon written notice by me, and the designation of the date on which I wish cancellation to take effect.

## Complete Your Enrollment

**Please return this completed form via mail in a postage-paid envelope to:**

Charles J. Sellers & Co., Inc.
4300 Camp Road
P.O. Box 460
Athol Springs, NY 14010

**Questions?**

Please contact our team at Charles J. Sellers for additional information.

716.627.5400
www.sellersinsurance.com