

Retiree/Military Accident and Health Insurance Enrollment Form

\$10.20

15.30

20.40

25.50

30.60

35.70

40.80

PO Box 3103, Frisco, TX 75034 Tel +1 866-506-1561 Fax +1 866-322-0239 Email: AAFES.QUESTIONS@aig.com

National Union Fire Insurance Company of Pittsburgh, Pa. New York, New York

\$ 50.000\*

75.000\*

100,000\*

125,000\*

150,000\*

175,000\*

200,000\*

POLICYHOLDER: Army and Air Force Exchange Services (AAFES) dba Exchange MASTER POLICY #: PAI 0009129205-A Retiree's Full Name: MI Last Name Date of Birth: Date Retired:\_\_\_\_ Street Address, City, State and Zip Code:\_\_\_\_\_ Phone Number: Retiree's Email Address: Retiree's Beneficiary Name \_\_\_\_\_\_ Relationship:\_\_\_\_\_ Street Address, City, State and Zip Code: If Retiree is married and designates someone other than his or her spouse as his/her beneficiary, written consent of the Retiree's spouse must accompany this Form. Select the Plan in which you wish to enroll: □ Self Only □ Family Coverage Annual Salary (As of last date worked) If you elect Family Plan, please complete the following: Name of Spouse: Names of Eligible Children: Unless additional beneficiaries are named in a separate statement attached hereto, you will be the beneficiary for your spouse and dependent children. **Principal Sum Selected by Retiree Semi-Annual Rate** Principal Sum Amount (Check one box below) **Retiree and Family** Retiree Only

6.59

9.89

13.18

16.48

19.77

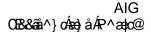
23.07

26.36

225,000\* 45.90 29.66 250,000\* 32.95 51.00 300,000\* 39.54 61.20 350,000\* 46.13 71.40 400.000\* 52.72 81.60 450.000\* 59.31 91.80 П 500,000\* 65.90 102.00

Your Effective Date: Your coverage will begin on the latest of: (1) the Policy Effective Date; (2) the date your premium is paid when due; or (3) the date this Enrollment Form is received by the Administrator.

<sup>\*</sup>Amounts selected in excess of \$300,000 may not exceed 10 times your salary at retirement.





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## CHANGE IN: 1. □ PLAN COVERAGE 2. □ PRINCIPAL SUM 3. □ CHANGE OF BENEFICIARY

I hereby revoke my beneficiary and/or plan coverage and section of amount principal sum previously made by me and enroll currently in the plan and Amount of Principal Sum as indicated by the boxes

## **CANCELLATION OF COVERAGE**

Retiree's Signature	Date Signed:
This form, when completed and properly validated, becomes part of your certificate. Your Coverage Effective Date will be the date your insurance begins. This form replaces and supersedes any such form previously completed by the retiree.	
For Retirees over age 65, to continue in the PAI plan, the premisinsurance benefit (principal sum) will be reduced to:  □ 65% upon attainment of age 70-74  □ 45% upon attainment of age 75-79  □ 30% upon attainment of age 80-84  □ 15% upon attainment of age 85 and older	ums will remain the same as prior to age 65, but the
If you have any questions, please contact the AIG Client Service AAFES.QUESTIONS@aig.com.	es at <b>866-506-1561</b> or email
I hereby request cancellation of my Accident and Health Insur	ance.

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