AIG
Accident and Health

Retiree/Military Accident and Health Insurance Enrollment Form

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

POLICYHOLDER: Army and Air Force Exchange Services (AAFES) dba Exchange
MASTER POLICY #: PAI 0009129205-A

Retiree's Full Name:_____
First MI Last Name

Date Retired:_____ Date of Birth:_____

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 Only**	**Retiree and Family**
☐ $ 50,000*	$ 6.59	$ $10.20
☐ 75,000*	9.89	15.30
☐ 100,000*	13.18	20.40
☐ 125,000*	16.48	25.50
☐ 150,000*	19.77	30.60
☐ 175,000*	23.07	35.70
☐ 200,000*	26.36	40.80
☐ 225,000*	29.66	45.90
☐ 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
☐ 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.
*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
☐ I hereby request cancellation of my Accident and Health Insurance.

If you have any questions, please contact the AIG Client Services at **866-506-1561** or email AAFES.QUESTIONS@aig.com**.**

For Retirees over age 65, to continue in the PAI plan, the premiums will remain the same as prior to age 65, but the insurance 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

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.

Retiree's Signature_____ Date Signed:_____

Return the form and your payment to:
Program Administrative Office
PO Box 3103
Frisco, TX 75034