# NYBEST / NY Life
# SCHOOL BLOCK Enrollment Form

daybright FINANCIAL

**Employer Section** (To be completed by the employer. Required fields are marked with an asterisk(*).)

| | | |
|---|---|---|
| *Employer Name: Mamaroneck UFSD | Effective Date: | Group ID: |
| | Class: | Occupation: |
| *Annual Salary: | *Date of Hire: | |

**Employee Section** (Please print clearly. Required fields are marked with an asterisk(*).)

| | | | |
|---|---|---|---|
| *Last Name: | *First Name: | | MI: |
| *SSN/ ID Number: | *Birth Date (MM/DD/YYYY): | *Gender: | *Marital Status: |
| *Street Address: | | | |
| *City: | *State: | *Zip Code: | |

**Long-Term Disability Coverage Election**

| | Enroll | Decline | Benefit Amount | Premium Amount |
|---|---|---|---|---|
| Long-Term Disability - Employee Only | ☒ | ☐ | _____ | (20/year) |

**Basic Life and AD&D Coverage Election**

| | Enroll | Decline | Benefit Amount | Premium Amount (20/Year) |
|---|---|---|---|---|
| Basic Life - Employee Only | ☒ | ☐ | _____ | Paid by Employer |

**Beneficiary for Death Benefits** (Right to change beneficiary is reserved to the insured.)

If naming more than one beneficiary, please attach a separate signed and dated sheet. Beneficiaries shall share benefits equally unless otherwise stated. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

**Primary Beneficiary Designation**

| Last Name | First Name | Relationship to Insured | Date of Birth (MM/DD/YYYY) | SSN |
|---|---|---|---|---|
| | | | | |
| Telephone: | Address of Beneficiary (Address, City, State, Zip): | | | |

**Secondary Beneficiary Designation**

| Last Name | First Name | Relationship to Insured | Date of Birth (MM/DD/YYYY) | SSN |
|---|---|---|---|---|
| | | | | |
| Telephone: | Address of Beneficiary (Address, City, State, Zip): | | | |

**Enrollment Information**

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the applicable policy). If you are required to pay premiums for any coverage, the enrollment form **MUST** be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the applicable policy as well as your age and/or salary on the effective date of the coverage.

**Employee Signature:**_____**Date:**_____