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 (20/year)
Long-Term Disability - Employee Only	☒	☐	_____	

Basic Life and AD&D Coverage Election

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

Voluntary Life and AD&D Coverage Changes for Current Policy Holders Only

Employee and Dependent Coverage	Benefit Amount - Select One Option	
Voluntary Life and AD&D - Employee	☐ Additional Life Insurance coverage in increments of $5,000 units with a maximum of $150,000 - $ _____	
	☐ Decline	
Voluntary Life - Spouse $5,000.00	☐ Enroll	☐ Decline
Voluntary Life - Child(ren) $2,000.00	☐ Enroll	☐ Decline

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:**_____