FULTON COUNTY EMPLOYEES' ASSOCIATION (FCEA)
MEMBERSHIP APPLICATION

INVOLVEMENT * UNITY * PROGRESS

AUTHORIZATION FOR PAYROLL DEDUCTION

Name of Employee:

TO: FULTON COUNTY, GEORGIA

Effective: ____________________________ I hereby request and authorize you to deduct from my

earnings each ______________ , the amount of $__________
(Pay Period Bi-weekly)

This amount shall be paid to the Fulton County Employees' Association, Inc. and represents payment of my membership dues.

This assignment and authorization should be continuous until revoked by me.

Received by ______________________________ Signed_________________________________

Last 4 of Social Security #: ___ ___ ___ ___

FOR FCEA BUSINESS OFFICE USE ONLY

APPLICATION FOR MEMBERSHIP
FULTON COUNTY EMPLOYEES' ASSOCIATION (FCEA)
ATLANTA, GEORGIA

Date: _____________, 2015

Applicant's Name: ____

Address: ________________________ **City:** ____________________ **State:** _____ **Zip Code:** _________

Department:	**Office Phone:**	**Mobile Phone:**

THANK YOU FOR JOINING FCEA!

Hartford Life and Accident Insurance Company

Life/Disability Enrollment Form

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name (Last Name, First Name and M.I.)			Birthday (MM/DD/YYYY)
Social Security Number	Sex ☐ Make ☐ Female	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widowed	Date of Marriage (MM/DD/YYYY

Employee Home Address: (Street, City, State and Zip Code)

Dependent Information: (Complete only if dependent coverage is available and elected) Last Name, First Name and M.I.			SEX: M/F	(DEPENDENT LIFE ONLY) BIRTHDAY (MM/DD/YYYY)
Spouse (Indicated last name if different from Employee)			☐ M ☐ F	
Child			☐ M ☐ F	
Child			☐ M ☐ F	
Child			☐ M ☐ F	
Child				

Indicate type of coverage below. You may only elect coverage reflected in your Employer's contract. (You will not be covered for coverage not included In your Employer's contract). To elect coverage check the box marked "Y"; to decline coverage check the box marked "N"

Basic Life	Supplemental Life	AD/D	Weekly Disability	LTD
☐ Y ☐ N Amount $______	☐ Y ☐ N ☐ $______ X Basic Amount Earning ☐ Other $______	☐ Y ☐ N	☐ Y ☐ N ☐ Flat Amount $______	☐ Y ☐ N

DEPENDENT LIFE				SUPPMENTAL AD/D	LTD BUY-UP
Spouse	☐ Y	☐ N	Amount $______	☐ Y ☐ N	Option 1 ______ %
Child	☐ Y	☐ N	Amount $______		Option 2 ______ %

Beneficiary Designation – Please refer to the reverse side of this form for important information regarding beneficiary designation.

	Full Name	**Address**	**Social Security No.**	**Relationship**	**Date of Birth**
Primary:					
Contingent:					

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages from my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between the Hartford and my Group Plan.

☐ I hereby waive the coverages offered to me. Understand that if I desire to apply for any of these coverages at a later date. I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature ____________________ Date: ____________________

TO BE COMPLETED BY THE EMPLOYER

Policy Symbol	Policy Number	Bill Unit	Loss Unit	Business Location State	Original Effective Date of Policy

EMPLOYEE NAME	EMPLOYEE HIRE DATE	EFFECTIVE DATE OF COVERAGE

EMPLOYEE OCCUPATION	EMPLOYEE CLALSS	LIFE	WD	LTF

Salary $______ ☐ Annual ☐ Monthly ☐ Weekly ☐ Hourly

TERMINATION DATE:	REINSTATEMENT DATE:

Our Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.

Naming Your Beneficiary

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(*ies*) please indicate their full name, address, social security number, relationship, if a minor, and the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, *"Not Related."* If you need assistance, contact your company representative or your own legal counsel.

Following are Examples of the most common Designations:

- Mary J. Doe, Wife (not Mrs. John Doe).
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.
- Estate of the Insured
- If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for Example: "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary(*ies*) than that provided on this form please complete a Beneficiary Designation Form **GR-11927.**