



American International Life Assurance Company of New York

New York, New York

A member company of American International Group, Inc.

Administrative Office: Client Services 3-A, 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583

Phone: 1-800-346-7692, Fax: 1-732-922-7604

Completing Your GROUP ENROLLMENT FORM
1. Fully complete each section
2. Sign and date Refusal/Authorization Section, as needed.
Group Policy No.(s)
NEW ENROLLMENT
CHANGE IN ENROLLMENT

1. PERSONAL DATA: (Must always be completed)
Division No., Class, Social Security No., Last Name, First Name, Initial
Sex, Date of Birth, Street Address, City, State, Zip Code
Name of Employer, Location, Salary \$ Per
Occupation, Title, Date of Full-Time Employment, No. Hours Worked
Marital Status, Dependent Children

2. ENROLLMENT
If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured.
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.
Name, Relationship, Date of Birth, Sex
SELF, X, , , ,

3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate
The amount for: Employee \$, Dependent \$

4. Beneficiary Designation: as is
EX: MARY A. JONES, WIFE First Name Initial Last Name Relationship
NOT MRS. JOHN JONES

5. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)
I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by American International Life Assurance Company of New York.
I am refusing: LTD, STD, Life/AD&D, Dependent Life, Supplemental Life/AD&D, All coverages offered
Dental: Employee & Dependents, Spouse, Child(ren), All Dependents
Vision: Employee & Dependents, Spouse, Child(ren), All Dependents

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:
Are you or your dependents now covered by any other group plan? YES NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If Yes: Policyholder's Name Carrier
I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.
I must furnish, at my expense, evidence of insurability satisfactory to American International Life Assurance Company of New York if I later wish to enroll in any other coverage that is now being refused.

DATE OF REFUSAL SIGNATURE IF REFUSING ANY COVERAGE
*IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.

6. AUTHORIZATION:
I hereby certify that all information furnished is true to the best of my knowledge.
I request group insurance for which I am or may become eligible.
I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to American International Life Assurance Company of New York.
I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by American International Life Assurance Company of New York.
I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to American International Life Assurance Company of New York information about me. Such information will pertain to my employment or other insurance coverage.

DATE SIGNED APPLICANT'S SIGNATURE