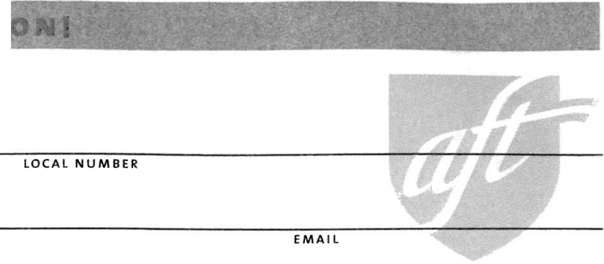
This form must be obtained from your site rep or an e-council member

SAMPLE



AFT LOCAL UNION NAME | LOCAL NUMBER

LAST NAME | FIRST NAME | EMAIL

Must have DOB

JOB TITLE | WORK LOCATION | DATE OF BIRTH

Must have SS#

SOCIAL SECURITY NUMBER | ( ) HOME PHONE | ( ) WORK PHONE

HOME ADDRESS | CITY | STATE | ZIP

I understand that my dues will include the many services and benefits of local, state, and national AFT bodies. Union dues may not be deductible for federal income tax purposes; however, under limited circumstances dues may qualify as a business expense.

AUTHORIZATION FOR MEMBERSHIP DUES WITHHOLDING

I hereby authorize payroll deduction from my salary for the payment of dues as set by the local union. This authorization will remain in effect until I revoke it in writing, unless specified otherwise in the local contract.

Must have signature and date by member here.

SIGNATURE | DATE

SUPPORT THE UNION'S COMMITTEE ON POLITICAL EDUCATION

I hereby authorize the (your employer)

SAMPLE

SIGNATURE | DATE

ACTIVATE $12,000 OF GROUP LIFE INSURANCE AT NO COST TO YOU

❑ **Yes!, I elect $12,000 of Group Term Life and Accidental Death & Dismemberment Insurance** which is available to me at no cost for one full year as a new AFT member. I want to be covered under the group plan for the benefits which I am or may become eligible for, as requested below. The AFT provides this insurance for one year as a benefit of AFT membership. After one year, I will be invited to continue the insurance.

My beneficiary is to be (please print)____________________ Relationship__________

My gender is ❑ male ❑ female. Must have beneficiary if yes checked

I hereby certify that all statements and answers in this form are full, complete, and true to the best of my knowledge and belief. I understand that to be eligible for coverage I must be a new AFT member, actively working, and not currently insured under the Group Term Life and Accidental Death & Dismemberment Insurance plan for [SAMPLE] coverage will become effective on the first day of the month after this completed and signed form is received at [SAMPLE] program administrator. The premiums for this insurance are being paid by AFT only for one year from the [SAMPLE] knowingly and with intent to defraud any insurance company or other person files an AFT application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. For questions, phone toll-free **(888) 423-8700** or visit **www.aftbenefits.org**.

Must have signature and date if insurance plan selected

SIGNATURE | DATE

February 2009

LOCAL UNION COPY

California Federation of Teachers, AFT, AFL-CIO

Insurance Activator Form