

JOIN THE UNION!

Please PRINT CLEARLY on all sections.

Coast Federation of Classified Employees

AFT Local 4794

LAST NAME	FIRST NAME	EMAIL	
JOB TITLE	WORK LOCATION	DATE OF BIRTH	
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.

SIGNATURE	DATE
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SUPPORT THE UNION'S COMMITTEE ON POLITICAL EDUCATION

I hereby authorize the Coast Community College District to deduct from my salary the sum of \$5 \$10 \$_____ (other amount) per pay period and forward that amount to the AFT Part-time Faculty United, Local 6286, Committee On Political Action (COPE). This authorization is signed freely and voluntarily and not out of any fear of reprisal and will not be favored or disadvantaged because I exercise this right. I understand this money will be used by CFCE/COPE to make political contributions. This voluntary authorization may be revoked at any time by notifying the Coast Federation of Classified Employees, AFT Local 4794, in writing of the desire to do so. Contributions or gifts to CFCE/COPE are not deductible as charitable contributions for federal tax purposes.

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

Yes, I elect \$12,000 of Group Term Life Insurance 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 be (please print) _____ Relationship _____

My gender is male female.

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 AFT members. I understand that my coverage will become effective on the first day of the month after this completed and signed form is received at the offices of the AFT PLUS insurance program administrator. The premiums for this insurance are being paid by AFT only for one year from the effective date. Any person who 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. Insured and administered by Metropolitan Life Insurance Company, New York, NY. For questions, phone toll-free **(888) 423-7800** or visit **www.aftinsurancecenter.org**.

SIGNATURE	DATE
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