CONFIDENTIAL
(When filled in)

Are you or any member of your family covered under any plan or plans for which payroll deductions are made, or for which an employer makes a contribution in whole or in part, or under Federal, State, or other Governmental Program which provides benefits for this illness or accident? Yes_____. No_____. If yes, give name and address of insurance company or other organization providing such coverage.

_____

_____

_____

$_____ was paid or will be paid by the other insurance company. (This payment must be reported to Association Plan before your claim can be processed. See page 17 of your official brichure regarding "Double Coverage".)

Date 20 September 19 62 Signed [redacted] Signature of Member

[redacted] for: Mario E. GIORDANO (P)

Group I
Excluded from Automatic
Downgrading and
Declassification

CONFIDENTIAL
(When filled in)