WVSSPA **Bigger – Better - Stronger**

1610 Washington St. E, Charleston, WV 25311 **ASSOCIATE MEMBER APPLICATION**

**Name:** _____ **Home E-Mail:** _____

**Address:** _____ **Home Phone:** _____ **Cell Phone:** _____

**City:** _____ **State:** _____ **Zip:** _____ ***Annual Dues $50.00** _____**Cash (Check or Money Order)**

***Dues money MUST be submitted with application. Please note: Our dues year is from September 1 through August 31 of each year. Renewal letters are mailed the end of July for the upcoming year, and dues MUST be received no later than September 30 of each year to continue membership without interruption of benefits. An associate member is not entitled to legal services. However, an associate member shall be entitled to receive any applicable benefits and publications of WVSSPA.**

**Eligibility requirements: An associate member must be of legal age (18) to hold membership with WVSSPA, and the member must be able to confirm the following statements to be true. 1) I am not under a doctor's care for any illness expected to end in death within the next 24 months. 2) I have not been diagnosed with cancer (this excludes skin cancer), or end stage heart failure, or renal failure.**
**By signing below I attest that all of the above statements are true.**

**Signed:** _____ **Date:** _____

## Designation of Beneficiary for $10,000 Term Life Policy

GUARDIAN

Policyholder **WV School Service Personnel Association**

Member's Name_____ Social Security No._____

Address_____ Date of Birth_____

County Of Employment_____ Email Address_____

Primary Beneficiary _____ DOB_____

Address _____

Contingent Beneficiary _____ DOB_____

Address _____

Signature of Member (required)_____ Date_____

**This card, when completed, is to be retained by WVSSPA until coverage under the policy terminates with respect to named member unless sooner changed or revoked by the member. The benefit reduces 50% at age 65 and the policy term ends at age 70.**

## Designation of Beneficiary for $25,000 Accidental Death and Dismemberment Policy

GUARDIAN

Policyholder **WV School Service Personnel Association**

Member's Name_____ Social Security No._____

Address_____ Date of Birth_____

County Of Employment_____ Email Address_____

Primary Beneficiary _____ DOB_____

Address _____

Contingent Beneficiary _____ DOB_____

Address _____

Signature of Member (required)_____ Date_____

**This card, when completed, is to be retained by WVSSPA until coverage under the policy terminates with respect to named member unless sooner changed or revoked by the member. The benefit reduces 50% at age 65 and the policy term ends at age 70.**