



**American Culinary Federation**  
The Standard of Excellence for Chefs

## Term Life Insurance

This complimentary term life insurance benefit is currently offered to members\* in good standing by the American Culinary Federation.

### The benefit currently offered to members\* in good standing by the American Culinary Federation is:

Death Benefit Amount: \$5,000 death benefit

Benefit Reduction: If the member is between the ages of 65 and 69, the policy provides a \$2,500 death benefit

Benefit Reduction: For Members age 70 and older, the policy provides a \$1,000 death benefit

\*This benefit is currently offered to Professional Culinarian, Culinarian, Student Culinarian, Senior Professional Culinarian, Allied and Associate members of the American Culinary Federation who are not members through the ACF Property or Military Program.

### Membership Death Benefit:

- (1) Contact the ACF membership department to notify us of death.
- (2) Claim form will be mailed to beneficiary and address on file.
- (3) The appropriate death benefit amount will be paid to the beneficiary named by the ACF member on the signed and dated form below.
- (4) ACF member dues must be current at the time of death to be eligible for benefit.
- (5) ACF will need a certified copy of death certificate in order to process claim.
- (6) Once ACF receives the claim form and certified copy of death certificate, processing will take approximately 2-3 weeks.

### Beneficiary:

- (1) Complete the form below and mail it back to the American Culinary Federation.
- (2) You can change the beneficiary by contacting the Membership department at 800-624-9458 and requesting a new beneficiary form.

Please return to: American Culinary Federation 180 Center Place Way, St. Augustine, FL 32095

## American Culinary Federation MEMBER BENEFICIARY INFORMATION

Name: \_\_\_\_\_ ACF Member #: \_\_\_\_\_ Chapter: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Day: \_\_\_\_\_ Evening: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: M F Place of Birth: \_\_\_\_\_

### Beneficiary of Insurance

Primary: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Address of Beneficiary: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_

Contingent Address: \_\_\_\_\_ Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Member's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_