American Culinary Federation

ACF Life Insurance Member Benefit

Eligibility Requirements and Beneficiary Selection Form

American Culinary Federation, Inc. • Attention: Membership • 6816 Southpoint Pkwy, Ste 400 • Jacksonville, FL 32216 • (800) 624-9458 • www.acfchefs.org

Benefit Eligibility Requirements

ACF's complimentary term life insurance benefit is provided to ACF members who meet the following eligibility requirements:

1. Were active ACF members as of 12/31/2020 and have remained active ACF members continually (without interruption) since then.
2. Were either a Professional Culinarian, Culinarian or Senior Culinarian member as of 12/31/2020.
   a. All other member levels are not eligible including those enrolled in the ACF Property and Military programs.
3. Any individual who joins ACF as a new member after 12/31/20 is ineligible for the ACF Member Life Insurance benefit.
4. Any former ACF member who lapsed prior to 12/31/20, and returns afterwards as a member, is ineligible for the benefit.

For questions on eligibility please email ACF at membership@acfchefs.org.

Benefit Payout/Amount

- If the member is 64 and younger, the benefit provides a $5,000 death benefit.
- If the member is between 65 and 69, the benefit provides a $2,500 death benefit.
- If the member is 70 and older, the benefit provides a $1,000 death benefit.

How to submit a benefit claim

1. Contact ACF Membership to notify us of death.
2. A claim form will be mailed to beneficiary and address on file.
3. A certified copy of death certificate is required to process the claim.
4. The appropriate death benefit amount will be paid to the beneficiary named by the ACF member on the signed and dated form below.
5. Once ACF receives the claim form and certified copy of death certificate, processing will take approximately 2-3 weeks.

Member Beneficiary Information

First Name: _____ MI: ___ Last Name: _____ ACF #: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Address: _____ ACF Chapter #: _____

City: _____ State: _____ Zip: _____

DOB: _____ Gender: ○ Male ○ Female Place of Birth: _____

Beneficiary of Insurance

Primary Beneficiary: _____ Relationship: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Contingent Beneficiary: _____ Relationship: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Member's Signature: _____ Date: _____