



Accidental Death (AD) Beneficiary Form  
 Customer Number TS05050044-G



Group Policyholder Name:  
Civil Service Employees Association, Inc.

**SECTION I – Insured Information**

First Name _____	M. _____	Last name _____	Date of Birth (mm/dd/yyyy) _____
Address – Street _____		Non-Work Email _____	Phone Number _____
City _____	State _____	Zip _____	SSN _____

**SECTION II – Beneficiary Information** Complete the section that pertains to the type beneficiary you are designating.

**PRIMARY BENEFICIARY** - Your first choice to receive your life insurance proceeds in the event of your accidental death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name _____	M. _____	Last name _____	Date of Birth _____
Address – Street _____		Phone Number _____	
City _____	State _____	Zip _____	SSN _____

**You MUST designate at least one primary beneficiary. A person may only be listed once. The sum MUST equal 100%.**

**CONTINGENT BENEFICIARY** - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name _____	M. _____	Last name _____	Date of Birth (mm/dd/yyyy) _____
Address – Street _____		Phone Number _____	
City _____	State _____	Zip _____	SSN _____

**The sum of the Primary & Contingent Beneficiary percentages MUST equal 100%. Dollar amounts, fractions and decimals will not be accepted.**

Relationship to Member _____	% Share _____
------------------------------	---------------

**If you need more space for additional beneficiaries, please use back of this form.**

**Submit completed form to CSEA, Inc., ATTN: Insurance Dept., 143 Washington Ave., Albany, NY 12210.**

**SECTION III – Signature & Attestation**

*I hereby authorize the Civil Service Employees Association, Inc. (CSEA), Local 1000 AFSCME, AFL-CIO, to be my exclusive representative for collective bargaining and therefore revoke any other representative that I may have previously designated. I also hereby authorize the fiscal or payroll officer of my employer to deduct CSEA dues from my salary in the amount certified by CSEA in this and succeeding years of my employment and membership. Dues, contributions or gifts to CSEA are not tax deductible as charitable contributions. However, they may be deductible as ordinary and necessary business expenses.*

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section II as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

**I acknowledge that my membership entitles me to this \$10,000 AD policy.**

Member Name (Please Print) _____	Member Signature _____
Date (Must be date form was completed) _____	_____

**CSEA Member Record Verification/Update**

*I hereby authorize the Civil Service Employees Association, Inc. (CSEA), Local 1000 AFSCME, AFL-CIO, to be my exclusive representative for collective bargaining and therefore revoke any other representative that I may have previously designated. I also hereby authorize the fiscal or payroll officer of my employer to deduct CSEA dues from my salary in the amount certified by CSEA in this and succeeding years of my employment and membership.*

*Dues, contributions or gifts to CSEA are not tax deductible as charitable contributions. However, they may be deductible as ordinary and necessary business expenses.*

Job Title _____	Place of Employment/Location _____	Non-Work Email Address _____
First Name _____	M. _____	Last name _____
Address – Street _____		Phone Number _____
City _____	State _____	Zip _____
		SSN _____

**I acknowledge that I am a Member in good standing, which entitles me to this \$10,000 AD policy.**

Member Name (Please Print) _____	Member Signature _____	Date _____
----------------------------------	------------------------	------------