MetLife

Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM (NEW YORK RESIDENTS ONLY)

CIVIL SERVICE EMPLOYEES ASSOCIATION (CSEA)

SC# 180148 | #191 Office

Member Name (First, Middle, Last)			Social Security #
Mailing Address (Street, City, State, Zip Code)			Date of Birth (MM/DD/YYYY)
Work Phone #	Home Phone #	Email Address	Employed By

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. I understand that I may also be eligible for Dependent Spouse Life Insurance and Dependent Child Life Insurance. I understand that contributions are required for the benefits I select below.

☐ Term Life [1]

Enter a multiple of $25,000 up to $100,000 under age 45; age 45-54 up to $50,000 Amount Requested $_____

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

GEF02-1
ADM

BENEFICIARY DESIGNATION

I designate the following person as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated.

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge: 1. I have read this enrollment form and declare that all information I have given, is true and complete to the best of my knowledge and belief. 2. I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work. 3. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose. 4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

⇨ _____ _____ _____

Signature of Member | Print Name | Date Signed (MM/DD/YYYY)

GEF09-1
DEC

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return: **via email: cseainsurance@pearlinsurance.com**
or fax: 1-877-217-4152
13 Airline Drive | Albany, NY 12205

CSEA EF-ST111M-NW (11/16)
Agent #191 Office |Marketing

PAYROLL DEDUCTION AUTHORITY for CSEA Membership

CSEA, Local 1000 AFSCME, AFL-CIO
143 Washington Avenue, Albany, New York 12210 / (518) 257-1000

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.

TO THE FISCAL OR PAYROLL OFFICER OF MY EMPLOYER:

I AM A MEMBER OF, OR HAVE APPLIED FOR MEMBERSHIP IN, CSEA AND HEREBY AUTHORIZE YOU TO DEDUCT FROM MY SALARY EACH PAYROLL PERIOD THE NECESSARY AMOUNTS FOR PAYMENT OF CSEA MEMBERSHIP DUES AND INSURANCE PREMIUMS (CHECK APPLICABLE BOXES, IF ANY):

SIGNATURE: _____ Date: _____

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss

(PLEASE PRINT)

_____
Name of CSEA LOCAL

_____ _____ _____ _____ _____
First MI Last Annualized Salary Job Title

_____
RESIDENCE street and number city state zip code

_____
WORK ADDRESS street and number city state zip code

_____ (_____) _____
Name of Agency and / or Facility Area Code Home Phone Number

_____ _____
EMPLOYED BY *Social Security Number*

☐ CHECK BOX IF YOU ARE A VETERAN

This space for CSEA office use only

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