Request for Group insurance from
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Request to New York Life Insurance Company for Group Hospital & Home Care Recovery Insurance

Guaranteed Issue Offer Application

Name: ______________________________

Address: ______________________________

City: ______________________ **State**: __________ **Zip**: __________

Email Address: ______________________________

Phone Number: ______________________ ☐ Home ☐ Cell ☐ Work

Date of Birth: ______________________ **Social Security #**: ______________________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Domestic Partnership

INSURANCE REQUESTED: (refer to brochure for eligibility and coverage description)

I hereby apply for Hospital & Home Care Recovery Insurance for:

☐ Member and: ☐ Spouse or ☐ Domestic Partner

Complete if enrolling Spouse or Domestic Partner ****Please note additional premium is required.***

Spouse/Domestic Partner Name: ______________________________

Spouse/Domestic Partner Sex: ☐ Male ☐ Female Spouse/Domestic Partner Date of Birth: ______________________

Spouse/Domestic Partner Social Security #: ______________________

Please note: Coverage is effective the first day of the month following the date the applocation and initial payment are received.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

By signing and dating this application, the member **requests** the insurance indicated; understands that this plan will not cover Pre-existing Conditions (A Pre-existing condition means an Injury, Sickness or Pregnancy or any related condition for which a person consults a doctor, receives medical services or supplies or takes any medication during the six month period immediately before the initial Insurance Date. A Preexisting Condition does not include any such condition after such person has been continuously insured under the Policy for six months.), and the member and any person proposed for insurance **attest** to having read the Fraud Notice indicated below, and to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: ______________________________ **Date**: ______________

Fraud Notice: **Residents of NY**: Any persons who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, informa-tion concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Questions? Call Pearl Insurance at 1-888-507-1368

CSEA Retiree Insurance Program
c/o Pearl Insurance | cseainsurance.com
1.888.507.1368 | *Enjoy Life. We Got This.*

CSEA Retiree Payment Options

Hospital & Home Care Recovery Insurance

You have 2 easy payment options as described below. Please note that to begin coverage, and with all payment options, **we first require a payment with your signed and dated application(s)**. Specific payment requirements for each payment option are listed below.

OPTION 1: Electronic Funds Transfer (EFT)

With Electronic Funds Transfer (EFT), you authorize your bank or financial institution to automatically deduct your monthly insurance premiums from your checking account. Paying your premiums by EFT is easy and convenient…save time writing checks and the postage cost to mail them…and there's no extra fee for installment payments!

Automatic withdrawals

- All withdrawals authorized will appear on your bank statement as "Pearl Insurance."
- Withdrawals will be taken on the first business day of the month.
- If your account does not have enough money, your bank may charge you for insufficient funds when we try to withdraw your payment. We will try to withdraw the money up to two times. If we are unsuccessful, we will notify you by mail of the missed payment and you may risk cancellation of the payment plan.
- If you cancel your policy before the current month's withdrawal date, we will notify you by mail of any balance due.

PAYMENT REQUIREMENT: First 2 months premium for initial payment

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OPTION 2: Direct Bill Sent to Your Home

You may opt to have a bill sent to your home based on the billing cycle you choose: Quarterly, Semi-Annually or Annually.

PAYMENT REQUIREMENT: Your initial premium payment will depend on the billing cycle you choose.

- For quarterly billing, **please include 3 months premium.**
- For semi-annual billing, **please include 6 months premium.**
- For annual billing, **please include 12 months premium.**

Effective Date Rules:

Application AND initial down payment received before 15th of month, *Effective date is the 1st of following month.*

Application AND initial down payment received after 15th of month, *Effective date is the 1st of the consecutive month.*

POLICYHOLDER INFORMATION *Please print*

Insured's Name (First, MI, Last Name)

Home Address (Street, City, State, Zip)

Daytime Phone | Email Address

OPTION 1: Electronic Funds Transfer (EFT)

If you choose to have your monthly premium deducted from your bank account, please complete below with your banking information and **include a check for your initial premium payment** - made payable to Pearl Insurance.

Bank Routing Number | Bank Account Number

Bank Name | Bank Account Owner's Name *(if different than Policyholder)*

AUTHORIZATION & SIGNATURE: I certify that I am the owner and/or authorized signer for this bank account, and I authorize Pearl Insurance NY ("Pearl Insurance") to make electronic debit entries for payment of insurance premiums for my policy(ies) from this account. The entries shall constitute my receipt for the transactions(s). I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account. I recognize that this authorization allows Pearl Insurance to adjust my scheduled deductions to reflect any premium changes. I understand that it is my responsibility to make sure that there are sufficient funds in this account at the monthly withdrawal date. I also understand that the policy(ies) may cancel or expire if there are insufficient funds in the account, pursuant to the terms of the policy(ies). This authorization is to remain in effect until Pearl Insurance receives written notification of its termination and has sufficient time to act on it.

Bank Account Owner's Signature | Date

Option 2: Direct Bill

If you choose to have your bill sent to your home, please select your billing cycle and **include a check for your initial premium payment** - made payable to Pearl Insurance. **Your initial premium payment will depend on the billing cycle you choose.**

CHECK ONE: ☐ Quarterly Bill ☐ Semi-Annual Bill ☐ Annual Bill

Member Signature | Date

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