CSEA

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

# CRITICAL ILLNESS RETIREE ENROLLMENT FORM

## GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

| Name of Group Customer/Employer | Group Customer # | Report # |
|---|---|---|
| Civil Service Employees Association (CSEA) | | |

## YOUR ENROLLMENT INFORMATION

| Name (First, Middle, Last) | | Social Security # | ☐ Male ☐ Female |
|---|---|---|---|
| Address (Street, City, State, Zip Code) | | Date of Birth (MM/DD/YYYY) | |
| Primary Phone # ☐ Cell ☐ Home | Secondary Phone # ☐ Cell ☐ Home | Email Address | |
| Date of Hire (MM/DD/YYYY) N/A | Employed By N/A | | |

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 have received and read a copy of the Outline of Coverage or other disclosure document for the Specified Disease Insurance. In certain states, this coverage may be referred to as Critical Illness Insurance, Specified Disease Insurance, Limited Benefit Insurance or Limited Benefit Critical Illness Insurance.

### Smoking Status Information for Specified Disease Insurance

| Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year? | Member | Spouse/Domestic Partner |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ N |

### Specified Disease Insurance

| Select your level of coverage: | |
|---|---|
| ☐ Member | ☐ Dependent Spouse/Domestic Partner[1] (up to a maximum of 100% of Member benefit amount) |
| Benefit Amount<br>☐ $10,000<br>☐ $20,000 | Benefit Amount<br>☐ $10,000<br>☐ $20,000 |

| | Member | Spouse/ Domestic Partner |
|---|---|---|
| For all persons to be insured is there coverage in force that provides benefits for at least major medical, or at least basic hospital and basic medical? | ☐Yes ☐No | ☐Yes ☐No |
| Do you or your spouse/domestic partner currently have coverage under, or currently have an application pending for, any other critical illness or specified disease policy? (If yes, please list who is covered and the conditions under the other policy(ies)) | ☐Yes ☐No | ☐Yes ☐No |

_____

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

### Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner, please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

CSEA Group Sponsored Insurance Programs
c/o Pearl Insurance
13 Airline Drive | Albany, NY 12205
www.cseainsurance.com

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

## FRAUD WARNINGS

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.

**GEF09-1**
**FW**

## BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) 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. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.

| Full Name (First, Middle, Last) | Social Security # | Date of Birth (Mo./Day/Yr.) | Relationship | Share % |
|---|---|---|---|---|
| Address (Street, City, State, Zip) | | | Phone # | |
| 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. | | | TOTAL: | 100% |

## DECLARATIONS AND SIGNATURE

Your Critical Illness certificate provides limited benefits. Read your certificate carefully.

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 understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
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**

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

# CSEA Retiree Payment Options

**(for Critical Illness, HHCR, Sr. Term Life)**

**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

## 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:***

**Sr. Term Life:** *Coverage is effective on application signature date however initial payment must be received for policy coverage to go in effect.*

**HHCR & Retiree Critical Illness:** *Direct Bill - Must have initial payment with the application and coverage starts 1st of following month. EFT - Must have 2 months premium and coverage begins on 1st of following 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

| Retiree Member: Non-Tobacco | | | | | Retiree Spouse: Non-Tobacco | | | |
|---|---|---|---|---|---|---|---|---|
| | $10,000 | | $20,000 | | $10,000 | | $20,000 | |
| Age | Mthly | Qtrly | Mthly | Qtrly | Mthly | Qtrly | Mthly | Qtrly |
| 50–54 | $17.50 | $52.50 | $35.00 | $105.00 | $17.50 | $52.50 | $35.00 | $105.00 |
| 55–59 | $26.50 | $79.50 | $53.00 | $159.00 | $26.50 | $79.50 | $53.00 | $159.00 |
| 60–64 | $38.00 | $114.00 | $76.00 | $228.00 | $38.00 | $114.00 | $76.00 | $228.00 |
| 65–69 | $56.40 | $169.20 | $112.80 | $338.40 | $56.40 | $169.20 | $112.80 | $338.40 |
| 70–74 | $79.90 | $239.70 | $159.80 | $479.40 | $79.90 | $239.70 | $159.80 | $479.40 |

| Retiree Member: Tobacco | | | | | Retiree Spouse Rate: Tobacco | | | |
|---|---|---|---|---|---|---|---|---|
| | $10,000 | | $20,000 | | $10,000 | | $20,000 | |
| Age | Mthly | Qtrly | Mthly | Qtrly | Mthly | Qtrly | Mthly | Qtrly |
| 50–54 | $30.80 | $92.40 | $61.60 | $184.80 | $30.80 | $92.40 | $61.60 | $184.80 |
| 55–59 | $47.30 | $141.90 | $94.60 | $283.80 | $47.30 | $141.90 | $94.60 | $283.80 |
| 60–64 | $67.90 | $203.70 | $135.80 | $407.40 | $67.90 | $203.70 | $135.80 | $407.40 |
| 65–69 | $101.20 | $303.60 | $202.40 | $607.20 | $101.20 | $303.60 | $202.40 | $607.20 |
| 70–74 | $142.80 | $428.40 | $285.60 | $856.80 | $142.80 | $428.40 | $285.60 | $856.80 |

*Your insurance (as well as any applicable coverage for your spouse/domestic partner who is not confined at home under a physician's care, receiving or applying to receive disability benefits, or hospitalized) will not become effective until your application has been approved and the 1st premium has been paid.*

*If a member is not able to perform normal activities on that date, coverage will take effect on the date you resume such activities and your premiums will be due at that time.*

*For coverage to become effective, the insured must have medical coverage in force on the effective date.*