



CSEA Group Sponsored Insurance Program
c/o Pearl Insurance | cseainsurance.com

This offer is good for new CSEA Members under the age of 70 within their first 180 days of membership.

Remember to **sign and date** both the application and payroll authorization form.

Please keep the Privacy Notice for your records.

Return this application by fax or scan and email:

Email: cseainsurance@pearlinsurance.com

Fax: 866.821.5062

Thank you for your participation in the CSEA Group Sponsored Insurance Program.

CSEA Premier Term Life Insurance

Guaranteed Issue Rates for New Members

Bi-Weekly Rates for \$50,000 in Coverage

Age Band	Under 30	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Member	\$2.30	\$3.80	\$5.40	\$7.50	\$11.10	\$18.00	\$25.40	\$38.10	\$59.90
Spouse	\$3.00	\$4.20	\$5.70	\$7.50	\$11.10	\$18.00	\$31.00	\$38.80	\$60.70

Bi-Weekly Rates for \$25,000 in Coverage

Age Band	Under 30	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69
Member	\$1.15	\$1.90	\$2.70	\$3.75	\$5.55	\$9.00	\$12.70	\$19.05	\$29.95
Spouse	\$1.50	\$2.10	\$2.85	\$3.75	\$5.55	\$9.00	\$15.50	\$19.40	\$30.35

Note: Spouse Rate is determined by the Member's age.

Sponsored by:

Brokered & Administered by:





Metropolitan Life Insurance Company, New York, NY 10166

**ENROLLMENT FORM FOR GROUP TERM LIFE INSURANCE
CIVIL SERVICE EMPLOYEES ASSOCIATION (CSEA) (GROUP CUSTOMER 5050044)
NY RESIDENTS ONLY FOR NEW CSEA MEMBERS UNDER THE AGE OF 70**

Name (First, Middle, Last)		Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Primary Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Secondary Phone # <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work	Date of Hire (MM/DD/YYYY)	
Email Address		Work Location	

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.

<input type="checkbox"/> Term Life ¹ <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> Dependent Child ³ <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
<input type="checkbox"/> Dependent Spouse/Domestic Partner ² Life ^{1,3} <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 The maximum amount of Spouse/Domestic Partner coverage cannot exceed the Member coverage amount.	

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)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female

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

- 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. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.
- ² 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.
- ³ Amounts will be subject to state limits, if applicable.

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ADM**

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

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.

**GEF17-1
FW**

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.

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DEC**

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to Pearl Insurance, 13 Airline Drive Albany , NY 12205.

**CSEA
EF-ST111M-NY (08/18)
Agent # _____**



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 and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. 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 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. The requirement that a dependent not be Hospitalized does not apply to newborn children. 4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing. 5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose. 6. 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)



Payroll Deduction Authority for CSEA Membership

CSEA, Local 1000 AFSCME, AFL-CIO

143 Washington Avenue, Albany, New York 12210 | Phone: 1-800-342-4146, x1314 • Fax: 518-465-2382

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 may revoke this authorization by sending a letter stating my intent to resign, along with my name, address, telephone number, and CSEA ID number, by United States Postal Service First Class Mail to: CSEA Statewide Secretary, Civil Service Employees Association, Inc., 143 Washington Avenue, Albany, N.Y. 12210.

TO THE FISCAL OFFICER OF MY EMPLOYER: I am a member of, or have applied for membership in, CSEA and thereby 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):

- TERM LIFE
- WHOLE/UNIVERSAL LIFE
- DISABILITY
- CAP
- CRITICAL ILLNESS
- HHCR
- AUTO/HOME

CHECK BOX IF YOU ARE A VETERAN

SALUTATION MR. MRS. MS. MISS

FIRST NAME MI LAST NAME

NICKNAME _____

MAILING ADDRESS _____

STREET ADDRESS

CITY STATE ZIP

PHONE _____

AREA CODE

LISTED UNLISTED

PHONE _____

AREA CODE

DATE OF BIRTH _____

mm dd yyyy

HOME E-MAIL _____

DO NOT GIVE YOUR WORK EMAIL ADDRESS.

NAME OF CSEA LOCAL _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____

NAME OF AGENCY/FACILITY

WORK ADDRESS _____

STREET ADDRESS

CITY STATE ZIP

WORK PHONE _____

AREA CODE

JOB TITLE _____

ANNUAL SALARY _____

Signature: _____

Date: _____

By checking this box I consent to receive calls (including recorded or autodialed calls or texts) at my cell phone number from CSEA and its affiliated labor organizations on any subject matter. You may modify your preferences by calling CSEA at 1-800-342-4146 or visiting the CSEA website at cseany.org.

C S E A O F F I C E U S E O N L Y



Delaware American Life Insurance Company
Hyatt Legal Plans, Inc.
Hyatt Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.