MetLife
Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT FORM FOR NEW YORK RESIDENTS ONLY

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #
Civil Service Members Association, Inc. (CSEA)	**129443**

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment	

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. For Minnesota and Vermont State residents- If I am enrolling for Accident Insurance: I declare that all individuals to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses. I have received and read a copy of the Outline of Coverage or other disclosure document for the Accident Insurance.

The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Accident Insurance

Select your level of coverage

☐ Member Only ☐ Member + Spouse/Domestic Partner [1] ☐ Member + Child(ren) ☐ Member + Spouse/Domestic Partner [1] + Child(ren)

IF I AM SELECTING ACCIDENT INSURANCE, I UNDERSTAND THAT THIS IS ACCIDENT-ONLY INSURANCE. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS. 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 ACKNOWLEDGE THAT I HAVE COMPREHENSIVE HOSPITAL, SURGICAL AND MEDICAL HEALTH INSURANCE (MINIMUM ESSENTIAL COVERAGE).

☐ Yes ☐ No

If you have questions about the benefits provided by this coverage, please contact us at 1-800-GET-MET8.

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

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

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

[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.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF02-1 ADM** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

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

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 Insurance): 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
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 FW** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
FW *applies to residents of North Dakota and Utah)*

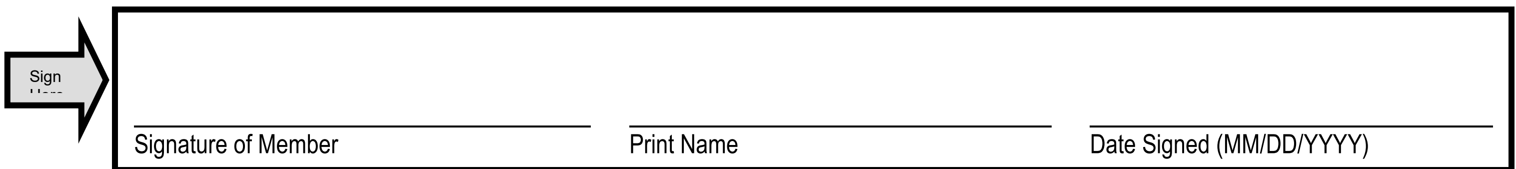
DECLARATIONS AND SIGNATURE

Your Accident 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 declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
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. **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.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Insurance): 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
DEC
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 DEC** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

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YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

Note: This notice is required by Louisiana law. MetLife does not collect or use genetic information in the sale, issuance, administration, or underwriting of its accident insurance product.

This notice is in connection with an enrollment in group (accident) insurance and information regarding your ("member", "spouse/domestic partners", and/or "child(ren)") rights related to the release and use of genetic information.

Genetic Information is defined as all information about genes, gene products, inherited characteristics, or family history/pedigree that is expressed in common language and **Genetic Information** shall include each of the following:

- an individual's genetic test;
- the genetic tests of the family members of an individual;
- the manifestation of a disease or disorder in family members of an individual;
- with respect to an individual or family member of an individual who is a pregnant woman, genetic information of any fetus or embryo carried by such pregnant woman; and with respect to an individual or family member of an individual utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

Genetic Information does not include the medical history of an individual insured or applicant for health care coverage and shall not mean information about the sex or age of any individual.

Genetic Services is defined as a genetic test, genetic counseling, including obtaining, interpreting, or assessing genetic information, or genetic education.

Genetic Test is defined as any test for determining the presence or absence of genetic characteristics in an individual, including tests of nucleic acids, such as DNA, RNA, and mitochondrial DNA, chromosomes, or proteins in order to diagnose or identify a genetic characteristic or that detects genotypes, mutation, or chromosomal changes. The determination of a genetic characteristic shall not include any diagnosis of the presence of disease, disability, or other existing medical condition.

Genetic Test shall not mean an analysis of proteins or metabolites that either:

- does not detect genotypes, mutations, or chromosomal changes;
- is directly related to a manifested disease, disorder, or pathological condition that could be reasonably detected by a health care professional with appropriate training and expertise in the field of medicine involved.

Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard shall **not**:

- request, require, or purchase genetic information of an individual or family member of an individual for underwriting purposes;
- request, require, or purchase genetic information of an individual or family member of an individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment;
- request or require that an individual, a family member of such individual, or a group member undergo a genetic test;
- establish rules for eligibility, including continued eligibility, of any individual or an individual's family member to enroll or continue enrollment based on genetic information;
- impose any preexisting condition exclusion on the basis of genetic information of an individual, family member of an individual, or group member;
- adjust premium or contribution amounts for an individual or group health plan on the basis of genetic information concerning the individual or a family member of the individual.

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

MetLife or any third party acting on MetLife's behalf is not precluded from obtaining and using the results of a genetic test in making a determination regarding payment. MetLife or any third party acting on MetLife's behalf may request, but not require, that an individual, family member of an individual, or a group member undergo a genetic test if:

- Compliance with the request is voluntary.
- Noncompliance will have no effect on enrollment status or premium, or contribution amounts.

MetLife or any third party acting on MetLife's behalf in this regard which is offering health insurance coverage obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation. The results of any genetic test, including genetic test information, shall not be used as the basis to:

- terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;
- cancel or refuse to renew the coverage of an individual or family member under the policy or plan;
- deny coverage or exclude an individual or family member from coverage under the policy or plan;
- impose a rider that excludes coverage for certain benefits or services under the policy or plan;
- establish differentials in premium rates or cost sharing for coverage under the policy or plan;
- otherwise discriminate against an individual or family member in the provision of insurance.

MetLife or any third party acting on MetLife's behalf in this regard, offering health insurance coverage may request only the minimum amount of information necessary to accomplish the intended purpose.

Nothing shall be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.

Authorization for Electronic Funds Transfer

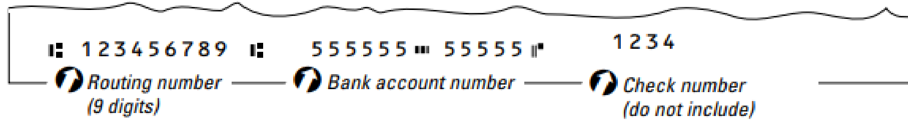
For automatic monthly payments

PEARL® INSURANCE

- Withdrawals will be taken on the first business day of the month ("Withdrawal Date").
- All withdrawals authorized will appear on your bank statement as "Pearl Insurance."
- 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.

Where to find your Bank Routing Number and Bank Account Number

If a checking account is being used, refer to the check diagram below to help determine your bank routing number and bank account number. If a savings account is being used, ask your bank to provide you with the correct bank transit routing number and account number for electronic withdrawals.



The authorization for automatic withdrawals shall remain in full force and effect until one of the following occurs:

- You notify Pearl Insurance at least five business days before a scheduled withdrawal date to either terminate this authorization or to prevent a scheduled payment.
- Pearl Insurance notifies you of termination of the authorization agreement.
- Your coverage is no longer in effect.
- The bank account authorized for withdrawals is closed or is otherwise terminated.

MEMBER INFORMATION

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

Home Address (Street, City, State, Zip)

( )

Phone – check one: ☐ Mobile ☐ Home ☐ Work   Personal Email Address

Coverages to be paid via EFT (check all that apply):

☐ Accident Insurance	☐ Critical Illness Insurance	☐ Dental Insurance
☐ Disability Insurance	☐ Hospital Income Insurance	☐ Hospital & Home Care Recovery
☐ Life Insurance	☐ Vision Insurance	☐ Other ____________

BANK INFORMATION

Bank Name   Bank Account Owner's Name *(if different than Member's Name above)*

☐ Checking ☐ Savings

Bank Routing Number   Bank Account Number

AUTHORIZATION & SIGNATURE

I certify that I am the owner and/or authorized signer for this bank account, and I authorize Pearl Insurance to make electronic debit entries for payment of insurance premiums 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 may cancel or expire if there are insufficient funds in the account, pursuant to the terms of the policy. 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