NEW YORK LIFE

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

# Request For Coverage Increase/Change
# CSEA Group Disability Income Insurance Plan

Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ ZIP: _____

Email: _____ Group Policy # G-11628-0

Preferred Phone Number: _____ ☐ Home ☐ Cell ☐ Work

**COVERAGE CHANGE REQUEST** I would like to:

☐ **Decrease** my CSEA Group Disability Insurance Monthly **Benefit Amount** from $_____/mth to $_____/mth

☐ **Change** my Group Disability Insurance **Waiting Period** from _____ Days to _____ Days

☐ **Change** my Group Disability Insurance **Benefit Duration** from _____ Mths to _____ Mths

☐ **Increase** Optional Accidental Death and Dismemberment coverage ☐ $10,000 ☐ $30,000 ☐ $50,000 ☐ $100,000

☐ **Decrease** my Optional Accidental Death & Dismemberment Benefit from $_____ to $_____

*$5,000 AD&D Included with Plan to remain*

☐ **Add** ☐ **Remove** Long-Term Accident (LTA) Benefit

☐ **Add** Optional Spouse Accident Disability Benefit ☐ $500 ☐ $1,000 ☐ **Remove Spouse**

**Spouse Name:** _____ **Spouse DOB:** _____

☐ **Increase** ☐ **Decrease** Optional Spouse Accident Disability Benefit $_____/mth to $_____/mth

☐ **Add** Optional Child Outpatient Emergency Accident Benefit: $50 per child – maximum of two outpatient visits per calendar year per child. (My child/ren is/are under age 19 as of the date of this application.)

I hereby request the change indicated above. I declare I am a CSEA Member currently insured in this program and understand that any change requested that requires additional premium will be deducted from my paycheck, provided I am at full time work on that date.

Signature of Member **X** _____ Date _____

***NOTE: If more space is needed, use a separate sheet of paper, signed and dated.***

**REQUEST FOR COVERAGE INCREASE** I hereby request that my monthly benefit under the CSEA Disability Income Insurance Plan be increased by: $_____ for a NEW total monthly benefit of $_____

**Under this offer, coverage may not be increased beyond a $1,200 Monthly Benefit maximum ($1,500 for Clerical Workers).**

*Pre-existing conditions may not be covered immediately- see Member's Declaration below for further details.*

**Member Declaration:** I hereby request the coverage increase as indicated above and attest to having read the Fraud Notice below. **I declare that I am a CSEA Member currently insured in this program.** I understand that this coverage increase will be effective on the date the additional premium due is deducted from my paycheck, provided I am at full-time work on that date. I also understand that this benefit increase will not be payable for any condition for which medical advice was given, or treatment was recommended by or received from a physician during the six month period before it is effective, until it has been continuously in force for 12 months.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement 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 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 **X** _____ Date _____

Please sign and date below, and send the request form in the enclosed postage-paid envelope or mail to:
Pearl Insurance
13 Airline Drive | Albany, NY 12205

Sponsored by: CSEA

Administered by: PEARL INSURANCE

**11628-Chg/Inc.21** **01/2021**

Assuming the Hospital & Home Care Recovery (HHCR) Group Policy remains in effect, a CSEA new retiree would be eligible to automatically become insured for the HHCR Guaranteed Issue benefit. The HHCR Group Policy will include a 10% rate discount and a waiver of the Preexisting Condition provision.

Do you wish to automatically enroll for the HHCR plan provided the HHCR Group Policy remains in effect? ❑ Yes ❑ No

# 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.

CSEA OFFICE USE ONLY