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)	Employed By		

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 ☐ $10,000 ☐ $20,000	Benefit Amount ☐ $10,000 ☐ $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.

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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)

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DEC

Select your Payment Method from the following 2 options:

☐ Option 1: Automatic Checking Account Withdrawal

If you choose to have your monthly premium deducted from your checking account, please:

1. Include a check for the first 2 months premium - made payable to Pearl Insurance (your Automatic Checking Account Withdrawals will begin after the first 2 months)

2. Sign the Checking Account Deduction Authorization below

Checking Account Deduction Authorization

I (we) hereby request and authorize you to effect a transfer each month on the account (name and number shown on check) for the payment of insurance premiums due during such month for the coverage that I have applied for. This authorization is to remain in effect until it is revoked by either of us in writing. Until you receive such written notice of revocation, I (we) agree that you shall be fully protected in processing such transfers. I (we) agree that if any such transfer is dishonored, the payment for insurance will be considered to be in default pursuant to the terms of the policy. This authorization shall be effective as of the date stated below. It is agreed that Pearl Insurance will automatically withdraw from my account the amount necessary to pay the monthly premium for the coverage(s) that I have applied for.

Signature: _____ **Date:** _____

☐ Option 2: Direct Bill Sent to Your Home

1. **Select your billing cycle (check one):**

☐ *Quarterly* ☐ *Semi-Annual* ☐ *Annual*

2. **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. Below is an illustration of the required initial premium payment based on your billing cycle.

Quarterly	*Semi-Annual*	*Annual*
Submit 3 months premium	Submit 6 months premium	Submit 12 months premium