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

Sponsored by: CSEA

Administered by: PEARL® INSURANCE
13 Airline Drive | Albany, NY 12205
www.cseainsurance.com

Group Comprehensive Accident Insurance Plan

Marketing | Office #191

Please use blue or black ink only. Do not use gel pens, correction fluids, or tape. All fields are required and initial any corrections.

1. MEMBER INFORMATION

Last Name	First Name	Initial	Social Security #

Home Address	City	State/Province	Zip Code

Email Address	Date of Birth *(mm/dd/yyyy)*	Sex	Are you presently working?
		☐ Male ☐ Female	☐ Yes ☐ No

2. SPOUSE INFORMATION

Last Name	First Name	Initial	Date of Birth *(mm/dd/yyyy)*	Sex
				☐ Male ☐ Female

Home Address (☐ *Same as Member*)	City	State/Province	Zip Code

3. I HEREBY APPLY FOR THE FOLLOWING COVERAGE PLAN *(Choose only one.)*

☐ **Coverage for Member Only**

Plan Benefit Amounts Combined:
$100 Accidental Hospital Indemnity Daily Benefit
$50 Emergency Room Benefit
$1,000 Accident Only Disability Monthly Benefit
$100,000 Accidental Death Lump Sum Benefit
$9.09 per bi-weekly paycheck

☐ **Coverage for Member and Spouse**

Plan Benefit Amounts Combined:
$100 Accidental Hospital Indemnity Daily Benefit
$50 Emergency Room Benefit
$1,000 Accident Only Disability Monthly Benefit
$100,000 Accidental Death Lump Sum Benefit
$18.18 per bi-weekly paycheck

BENEFICIARY: Unless otherwise requested, your spouse, if living will be the beneficiary of your Accidental Death benefit, otherwise, the death benefit will be paid to your surviving relative(s) in the following order of survival: spouse, children equally, parents equally, brother or sisters equally, or your estate.

4. PAYMENT OPTION SELECTED *(Choose only one.)*

☐ **Option 1 (Periodic Billing):** ☐ Quarterly ☐ Semi-Annual ☐ Annual

■ **Option 2 (Payroll Allotment):** ■ Bi-weekly Payroll Allotment

I hereby authorize the necessary salary deductions for the premium once approved for coverage, to pay for insurance for the Comprehensive Accident Insurance Plan. This authority is to remain in effect until it is cancelled by written notice to the Plan Administrator.

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.

READ AND SIGN:

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **attest** to having read the Fraud Notice on the back of this page, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature *(Required - Please sign and date in ink.)*	Date *(mm/dd/yyyy)*

Spouse's Signature	Date *(mm/dd/yyyy)*

PAYROLL DEDUCTION AUTHORITY for CSEA Membership

CSEA, Local 1000 AFSCME, AFL-CIO
143 Washington Avenue, Albany, New York 12210 / (518) 257-1000

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.

TO THE FISCAL OR PAYROLL OFFICER OF MY EMPLOYER:

I AM A MEMBER OF, OR HAVE APPLIED FOR MEMBERSHIP IN, CSEA AND HEREBY 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):

SIGNATURE: _____ Date: _____

☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss

(PLEASE PRINT)

_____
Name of CSEA LOCAL

_____ _____ _____ _____ _____ _____
First MI Last Annualized Salary Job Title

_____
RESIDENCE street and number city state zip code

_____
WORK ADDRESS street and number city state zip code

_____ (_____) _____
Name of Agency and / or Facility Area Code Home Phone Number

_____ _____
EMPLOYED BY *Social Security Number*

☐ CHECK BOX IF YOU ARE A VETERAN

This space for CSEA office use only

Rev. 3/13

SUBMISSION INSTRUCTIONS

Be sure to SIGN enrollment and payroll authorization forms,
make a copy for your records and return:
via email: cseainsurance@pearlinsurance.com
or fax: 1-866-821-5062
13 Airline Drive | Albany, NY 12205