Request for Group Insurance from
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
The Company You Keep©

Sponsored by:

Administered by:

13 Airline Drive | Albany, NY 12205
www.cseainsurance.com

Group Disability Income Insurance Plan
Guaranteed Issue Application for CSEA Members

1. MEMBER NAME AND INFORMATION:

LAST: ______________________ FIRST: ______________________ MIDDLE: ______________ SEX: ❑ MALE ❑ FEMALE

ADDRESS: ______________________________ CITY: ______________ STATE: __________ ZIP: __________

SSN: ____________________ CELL PHONE#: (_____) ____________ WORK PHONE#: (_____) ____________

EMAIL: ______________________________________ DATE OF BIRTH: ______/______/__________
MM DD YYYY

2. MEMBER AFFILIATION / OCCUPATION:

A. Are you now a member of CSEA?.. ❑ YES ❑ NO

B. Work address: ______________________________________ Date employed? ______________

C. Are you presently performing all the duties of your occupation according to your regular schedule?.............. ❑ YES ❑ NO

D. Are you solely engaged in office or clerical work? .... ❑ YES ❑ NO

E. What is your annual salary?.. $__________

F. Describe your occupation/duties: ____

3. INSURANCE REQUESTED:

I hereby apply for the coverage indicated below based upon all my statements made in this application.
You may choose any Monthly Benefit from $300 to $1,200 per month ($1,500 per month for clerical workers) provided it does not exceed the benefit amount based on your current salary.

A. Monthly Benefit: $______________
B. Waiting Period in Days: ❑ 0 Accident/7 Sickness ❑ 30 Accident/30 Sickness
C. Maximum Benefit Period: ☒ 6 Months
D. Optional Accidental Death and Dismemberment Benefit: ❑ $10,000 ❑ $30,000 ❑ $50,000 ❑ $100,000
E. Optional Spouse Accident Disability Only Coverage: ❑ $500 Monthly Benefit ❑ $1,000 Monthly Benefit
(maximum 6 month benefit duration) Spouse Name: ____________________ Spouse DOB: ____________________

BENEFICIARY DESIGNATION: Unless otherwise requested, your spouse, if living will be the beneficiary of your AD&D 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, brothers or sisters equally, or your estate.

By signing and dating this application, the member **requests** the insurance indicated; and the member **attests** to having read the Fraud Notice indicated below and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

I understand that benefits 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 6 month period before my effective date, until my coverage 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 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 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 IN INK

11628-Basic

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

10/16 ed

AGENT#	SOURCE CODE:	APP #:	APPROVED BY:

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