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

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

Marketing | Office #191

Name:_____

Address:_____

City:_____State:_____ZIP: _____

Group Policy # G-11628-0 Email Address: _____

Preferred Phone Number _____ ☐Home ■Cell ☐ Work

Date of Birth:_____Social Security #:_____

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_____months to_____months.

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

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

☐ **Increase** ☐ **Decrease** Optional Spouse Accident Disability Benefit from $_____to $_____

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

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 **rev 10/16**

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

CSEA GROUP SPONSORED DISABILITY INSURANCE
GUARANTEED ISSUE MONTHLY BENEFIT AMOUNTS & RATES

Additional benefit and waiting periods also available. Ask your CSEA Insurance Representative.

OFFICE/CLERICAL	Annual Salary Requirement of:	Monthly Benefit	Member's Attained Age			
			Under 30	30-39	40-49	50-59
CSEA Members who are **solely engaged** in office or clerical work. ***0-day Accident, 7-day Sickness waiting period. Benefits payable up to 12 months for covered disability due to Accident or Sickness.***	*$10,000 - $11,999*	**$ 500**	$ 7.87	$ 9.80	$ 12.41	$ 17.31
	$12,000 - $13,999	**$ 600**	$ 9.39	$ 11.71	$ 14.84	$ 20.69
	$14,000 - $17,999	**$ 700**	$ 10.91	$ 13.61	$ 17.27	$ 24.07
	$18,000 - $21,999	**$ 800**	$ 12.44	$ 15.52	$ 19.70	$ 27.46
	$22,000 - $25,999	**$ 900**	$ 13.96	$ 17.43	$ 22.13	$ 30.84
	$26,000 - $27,499	**$ 1,000**	$ 15.49	$ 19.34	$ 24.56	$ 34.23
	$27,500 - $29,999	**$ 1,100**	$ 17.01	$ 21.24	$ 26.99	$ 37.61
	$30,000 - $32,499	**$ 1,200**	$ 18.53	$ 23.15	$ 29.42	$ 40.99
	$32,500 - $34,999	**$ 1,300**	$ 20.06	$ 25.06	$ 31.85	$ 44.38
	$35,000 - $37,499	**$ 1,400**	$ 21.58	$ 26.96	$ 34.28	$ 47.76
	$37,500 - $39,999	**$ 1,500**	$ 23.11	$ 28.87	$ 36.71	$ 51.15

Monthly benefit amounts over $1,500 and up to $3,000 subject to medical questions & underwriting.

NON-CLERICAL	Annual Salary Requirement of:	Monthly Benefit	Member's Attained Age			
			Under 30	30-39	40-49	50-59
CSEA Members who are **NOT** engaged in office or clerical work. ***0-day Accident, 7-day Sickness waiting period. Benefits payable up to 12 months for covered disability due to Accident or Sickness.***	*$10,000 - $11,999*	**$ 500**	$ 12.10	$ 14.92	$ 19.19	$ 26.56
	$12,000 - $13,999	**$ 600**	$ 14.44	$ 17.82	$ 22.93	$ 31.77
	$14,000 - $17,999	**$ 700**	$ 16.78	$ 20.72	$ 26.66	$ 36.98
	$18,000 - $21,999	**$ 800**	$ 19.12	$ 23.63	$ 30.40	$ 42.19
	$22,000 - $25,999	**$ 900**	$ 21.46	$ 26.53	$ 34.14	$ 47.40
	$26,000 - $27,499	**$ 1,000**	$ 23.80	$ 29.44	$ 37.88	$ 52.62
	$27,500 - $29,999	**$ 1,100**	$ 26.14	$ 32.34	$ 41.61	$ 57.83
	$30,000 - $32,499	**$ 1,200**	$ 28.48	$ 35.24	$ 45.35	$ 63.04

Monthly benefit amounts over $1,200 and up to $3,000 subject to medical questions & underwriting.

Optional Spouse Accident Disability Coverage	Monthly Benefit	*Spouse Attained Age*			
		Under 30	30-39	40-49	50-59
Choice of a $500 or $1,000 monthly benefit. Guaranteed Issue with no health questions asked. Benefits payable up to 6 months.	**$ 500**	$ 2.00	$ 2.50	$ 3.25	$ 4.25
	$ 1,000	$ 4.00	$ 5.00	$ 6.50	$ 8.50

For the Member Disability Income plan, rates are based on the Member's attained age on the first day of any insurance period.
For Spouse Accident Disability coverage, rates are based on the Spouse's attained age on the first day of any insurance period.
Rates increase following attainment of a new age bracket. Rates are based on 26 bi-weekly pay period frequency.

Insured members must notify Pearl Insurance his or her Job Classification changes from Office or Clerical Work to Non-Office or Clerical Work or vice versa. Notification of such change should be made immediately, but in no event more than 90 days after the date his or her Job Classification changes.

Benefits are subject to change by agreement between New York Life and CSEA. Rates may be changed by New York Life on any premium due date and on any date on which benefits are changed. However, your benefits may change only if they are changed for an entire class of insureds. For example, a class is a group of people with the same issue age. Please refer to the plan brochure for complete plan information including eligibility, benefits, exclusions & limitations, termination provisions etc. CSEA's Sponsored Group Disability Income Insurance Plan is underwritten by New York Life Insurance Company, 51 Madison Ave., New York, NY 10010 (Policy Form GMR).

CSEA
Group Sponsored Insurance Program
c/o Pearl Insurance | cseainsurance.com

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

Group Sponsored Insurance Program
c/o Pearl Insurance | cseainsurance.com

Remember to sign and date both the application and PDA form.

Return this application by fax or scan and email:

Email: cseainsurance@pearlinsurance.com

Fax: 866.821.5062

Thank you for your participation in the CSEA Group Sponsored Insurance Program.