



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



**PEARL®  
INSURANCE**  
13 Airline Drive | Albany, NY 12205  
www.cseainsurance.com

**Group Disability Income Insurance Plan  
Guaranteed Issue Application for CSEA Members**

*Marketing | Office #191*

**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:  \$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

AGENT#	SOURCE CODE:	APP #:	APPROVED BY:
--------	--------------	--------	--------------

Rates are current as of 2019 and based on 26 bi-weekly pay period frequency.

CSEA GROUP DISABILITY PLAN - BASIC PLAN													
CLERICAL							NON-CLERICAL						
6 Month Benefit							0-7 Day Wait						
0-day Accident, 7-day Sickness waiting period. Benefits payable up to 6 months for covered disability due to Accident or Sickness. 7-day waiting period for Pregnancy, with benefits payable like any other sickness disability.							0-day Accident, 7-day Sickness waiting period. Benefits payable up to 6 months for covered disability due to Accident or Sickness. 7-day waiting period for Pregnancy, with benefits payable like any other sickness disability.						
Annual Salary	Monthly Benefit	Insured Members's Age					Annual Salary	Monthly Benefit	Insured Members's Age				
		Under 30	30-39	40-49	50-59	60-64**			Under 30	30-39	40-49	50-59	60-64**
\$5,000 - \$7,499	\$ 300	\$ 3.51	\$ 4.43	\$ 5.60	\$ 8.07	\$ 9.59	\$5,000 - \$7,499	\$ 300	\$ 5.47	\$ 6.64	\$ 8.07	\$ 12.50	\$ 14.60
\$7,500 - \$9,999	\$ 400	\$ 4.59	\$ 5.81	\$ 7.38	\$ 10.67	\$ 12.70	\$7,500 - \$9,999	\$ 400	\$ 7.16	\$ 8.72	\$ 10.62	\$ 16.54	\$ 19.33
\$10,000 - \$11,999	\$ 500	\$ 5.68	\$ 7.20	\$ 9.16	\$ 13.28	\$ 15.81	\$10,000 - \$11,999	\$ 500	\$ 8.85	\$ 10.81	\$ 13.18	\$ 20.58	\$ 24.07
\$12,000 - \$13,999	\$ 600	\$ 6.76	\$ 8.59	\$ 10.94	\$ 15.88	\$ 18.92	\$12,000 - \$13,999	\$ 600	\$ 10.54	\$ 12.89	\$ 15.74	\$ 24.62	\$ 28.80
\$14,000 - \$17,999	\$ 700	\$ 7.84	\$ 9.97	\$ 12.72	\$ 18.48	\$ 22.03	\$14,000 - \$17,999	\$ 700	\$ 12.23	\$ 14.97	\$ 18.29	\$ 28.66	\$ 33.53
\$18,000 - \$21,999	\$ 800	\$ 8.93	\$ 11.36	\$ 14.50	\$ 21.09	\$ 25.14	\$18,000 - \$21,999	\$ 800	\$ 13.92	\$ 17.06	\$ 20.85	\$ 32.70	\$ 38.27
\$22,000 - \$25,999	\$ 900	\$ 10.01	\$ 12.75	\$ 16.28	\$ 23.69	\$ 28.25	\$22,000 - \$25,999	\$ 900	\$ 15.61	\$ 19.14	\$ 23.41	\$ 36.74	\$ 43.00
\$26,000 - \$27,499	\$ 1,000	\$ 11.10	\$ 14.14	\$ 18.06	\$ 26.30	\$ 31.37	\$26,000 - \$27,499	\$ 1,000	\$ 17.30	\$ 21.23	\$ 25.97	\$ 40.79	\$ 47.74
\$27,500 - \$29,999	\$ 1,100	\$ 12.18	\$ 15.52	\$ 19.84	\$ 28.90	\$ 34.48	\$27,500 - \$29,999	\$ 1,100	\$ 18.99	\$ 23.31	\$ 28.52	\$ 44.83	\$ 52.47
\$30,000 - \$32,499	\$ 1,200	\$ 13.26	\$ 16.91	\$ 21.62	\$ 31.50	\$ 37.59	\$30,000 - \$32,499	\$ 1,200	\$ 20.68	\$ 25.39	\$ 31.08	\$ 48.87	\$ 57.20
\$32,500 - \$34,999	\$ 1,300	\$ 14.35	\$ 18.30	\$ 23.40	\$ 34.11	\$ 40.70	\$32,500 - \$34,999	\$ 1,300	\$ 22.37	\$ 27.48	\$ 33.64	\$ 52.91	\$ 61.94
\$35,000 - \$37,499	\$ 1,400	\$ 15.43	\$ 19.68	\$ 25.18	\$ 36.71	\$ 43.81	\$35,000 - \$37,499	\$ 1,400	\$ 24.06	\$ 29.56	\$ 36.19	\$ 56.95	\$ 66.67
\$37,500 - \$39,999	\$ 1,500	\$ 16.52	\$ 21.07	\$ 26.96	\$ 39.32	\$ 46.92	\$37,500 - \$39,999	\$ 1,500	\$ 25.75	\$ 31.65	\$ 38.75	\$ 60.99	\$ 71.41
\$40,000 - \$42,499	\$ 1,600	\$ 17.60	\$ 22.46	\$ 28.74	\$ 41.92	\$ 50.03	\$40,000 - \$42,499	\$ 1,600	\$ 27.44	\$ 33.73	\$ 41.31	\$ 65.03	\$ 76.14
\$42,500 - \$44,999	\$ 1,700	\$ 18.68	\$ 23.84	\$ 30.52	\$ 44.52	\$ 53.14	\$42,500 - \$44,999	\$ 1,700	\$ 29.13	\$ 35.81	\$ 43.86	\$ 69.07	\$ 80.87
\$45,000 - \$47,499	\$ 1,800	\$ 19.77	\$ 25.23	\$ 32.30	\$ 47.13	\$ 56.25	\$45,000 - \$47,499	\$ 1,800	\$ 30.82	\$ 37.90	\$ 46.42	\$ 73.11	\$ 85.61
\$47,500 - \$49,999	\$ 1,900	\$ 20.85	\$ 26.62	\$ 34.08	\$ 49.73	\$ 59.36	\$47,500 - \$49,999	\$ 1,900	\$ 32.51	\$ 39.98	\$ 48.98	\$ 77.15	\$ 90.34
\$50,000 - \$54,999	\$ 2,000	\$ 21.94	\$ 28.01	\$ 35.86	\$ 52.34	\$ 62.48	\$50,000 - \$54,999	\$ 2,000	\$ 34.20	\$ 42.07	\$ 51.54	\$ 81.20	\$ 95.08
\$55,000 - \$59,999	\$ 2,100	\$ 23.02	\$ 29.39	\$ 37.64	\$ 54.94	\$ 65.59	\$55,000 - \$59,999	\$ 2,100	\$ 35.89	\$ 44.15	\$ 54.09	\$ 85.24	\$ 99.81
\$60,000 - \$64,999	\$ 2,200	\$ 24.10	\$ 30.78	\$ 39.42	\$ 57.54	\$ 68.70	\$60,000 - \$64,999	\$ 2,200	\$ 37.58	\$ 46.23	\$ 56.65	\$ 89.28	\$ 104.54
\$65,000 - \$69,999	\$ 2,300	\$ 25.19	\$ 32.17	\$ 41.20	\$ 60.15	\$ 71.81	\$65,000 - \$69,999	\$ 2,300	\$ 39.27	\$ 48.32	\$ 59.21	\$ 93.32	\$ 109.28
\$70,000 - \$74,999	\$ 2,400	\$ 26.27	\$ 33.55	\$ 42.98	\$ 62.75	\$ 74.92	\$70,000 - \$74,999	\$ 2,400	\$ 40.96	\$ 50.40	\$ 61.76	\$ 97.36	\$ 114.01
\$75,000 - \$79,999	\$ 2,500	\$ 27.36	\$ 34.94	\$ 44.76	\$ 65.36	\$ 78.03	\$75,000 - \$79,999	\$ 2,500	\$ 42.65	\$ 52.49	\$ 64.32	\$ 101.40	\$ 118.75
\$80,000 - \$84,999	\$ 2,600	\$ 28.44	\$ 36.33	\$ 46.54	\$ 67.96	\$ 81.14	\$80,000 - \$84,999	\$ 2,600	\$ 44.34	\$ 54.57	\$ 66.88	\$ 105.44	\$ 123.48
\$85,000 - \$89,999	\$ 2,700	\$ 29.52	\$ 37.71	\$ 48.32	\$ 70.56	\$ 84.25	\$85,000 - \$89,999	\$ 2,700	\$ 46.03	\$ 56.65	\$ 69.43	\$ 109.48	\$ 128.21
\$90,000 - \$94,999	\$ 2,800	\$ 30.61	\$ 39.10	\$ 50.10	\$ 73.17	\$ 87.36	\$90,000 - \$94,999	\$ 2,800	\$ 47.72	\$ 58.74	\$ 71.99	\$ 113.52	\$ 132.95
\$95,000 - \$99,999	\$ 2,900	\$ 31.69	\$ 40.49	\$ 51.88	\$ 75.77	\$ 90.47	\$95,000 - \$99,999	\$ 2,900	\$ 49.41	\$ 60.82	\$ 74.55	\$ 117.56	\$ 137.68
\$100,000 - \$104,999	\$ 3,000	\$ 32.78	\$ 41.88	\$ 53.66	\$ 78.38	\$ 93.59	\$100,000 - \$104,999	\$ 3,000	\$ 51.10	\$ 62.91	\$ 77.11	\$ 121.61	\$ 142.42

\*All rates include \$5,000 Basic AD&D Coverage. \*\*Age 65+ For renewal only.

\*All rates include \$5,000 Basic AD&D Coverage. \*\*Age 65+ For renewal only.

**For All Premiums**

Rates are based on the Member's attained age on the first day of any insurance period. Rates increase following attainment of a new age bracket, i.e. 30, 40, 50, etc. 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. 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., NY, NY 10010 (Policy Form GMR) INSURED MEMBER must notify Pearl Insurance if 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.



# 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](http://cseany.org).

C S E A   O F F I C E   U S E   O N L Y



**Group Sponsored Insurance Program**  
c/o Pearl Insurance | [cseainsurance.com](http://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](mailto:cseainsurance@pearlinsurance.com)

Fax: 866.821.5062

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