MetLife

Metropolitan Life Insurance Company, New York, NY 10166

PEARL® INSURANCE | CSEA

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

ENROLLMENT • CHANGE FORM FOR RETIREE DENTAL

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Association	Group Customer #
Civil Service Employees Association (CSEA)	05050023

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment	

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.

Dental Insurance

Select your level of coverage

- ☐ Member Only
- ☐ Member + One Dependent (Spouse/Domestic Partner[1] or Child)
- ☐ Member + Two or More Dependents (Spouse/Domestic Partner[1] and Children)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

Payment Information

Select the method of payment

- ☐ Monthly ACH automatic deduction from checking account (please complete withdrawal form)
- ☐ Monthly automatic deduction from my pension account (please complete withdrawal form)
- ☐ Direct Bill sent to your home:
  - ☐ Quarterly ☐ Semiannually ☐ Annually

[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.

GEF02-1
ADM
(*The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original
to Pearl Insurance, 13 Airline Drive Albany, NY 12205
Toll-free phone: 1-888-507-1368

Civil Service Employees Association (CSEA)
EF-ST200M-NY (02/17)

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FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued. Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties. 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. Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement may have violated the state law. Pennsylvania and all other states: 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 subjects such person to criminal and civil penalties.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
FW *applies to residents of North Dakota and Utah)*

DECLARATIONS AND SIGNATURE

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 authorize Civil Service Employees Association (CSEA) to deduct the required contributions for my coverage as outlined in the Payment Information section. This authorization applies to such coverage until I rescind it in writing.
3. 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.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC
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GEF09-1
DEC *applies to residents of North Dakota and Utah)*

Select your Payment Method from the following 3 options:

Option 1: Automatic Pension Deduction

Note: You must currently be receiving a New York State pension to select this payment method.

If you choose to have your monthly premium deducted from your New York State Pension check, please:

1. **Include a check for the first 2 months premium - made payable to Pearl Insurance (your Pension Deductions will begin after the first 2 months)**
   - *2 Months | Member:* **$93.56**
   - *2 Months | Family:* **$224.48**
   - *2 Months | Member + 1 (Spouse or Child):* **$172.32**

2. **Sign the Pension Deduction Authorization below**

Pension Deduction Authorization

Pursuant to Section 110-c and 410c of the Retirement and Social Security Law, I hereby authorize deductions to be made from my monthly allowance from the New York State and Local Employees Retirement Systems in the amount necessary to cover membership dues and insurance on my behalf to CSEA, Local 1000, AFSCME, AFL-CIO. Authorization is also given to make any changes the Union certifies to the Retirement System as necessary in the amount of such dues and insuranc-es. I, the undersigned, do hereby authorize you to deduct from my monthly allowance the amount of $3.00 for payment of dues, or any amount as may be certified to you by the Union as my dues and or insurance. I understand that CSEA, Local 1000, AFSCME, AFL-CIO is my agent and all request to begin, modify, or revoke deductions must be submitted through the Union. This authorization shall remain in effect until revoked by me by written notice through the Union or until otherwise revoked pursuant to law.

Signature: _____ **Date:** _____

Option 2: 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 Months | Member:* **$93.56**
   - *2 Months | Family:* **$224.48**
   - *2 Months | Member + 1 (Spouse or Child):* **$172.32**

2. **Sign the Checking Account Deduction Authorization below**

Checking Account Deduction Authorization

I (wehereby request and authorize you to effect a transfer each month on the account (name and number shown on checkfor 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 (weagree that you shall be fully protected in processing such transfers. I (weagree that if any such transfer is dishonored, the pay-ment 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(sthat I have applied for.

Signature: _____ **Date:** _____

Option 3: 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***
   Submit 3 months premium

   ☐ ***Semi-Annual***
   Submit 6 months premium

   ☐ ***Annual***
   Submit 12 months premium

If you have any questions contact an insurance representative at 1-866-478-8907