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

Request to New York Life Insurance Company for Group Hospital & Home Care Recovery Insurance

Guaranteed Issue Offer Application

180110 Marketing | Office #191

Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____

Phone Number: (_____)_____ ☐ Home ☐ Cell ☐ Work

Date of Birth: _____ **Social Security #**: _____

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Married ☐ Single ☐ Domestic Partnership

INSURANCE REQUESTED: (refer to brochure for eligibility and coverage description)

I hereby apply for Hospital & Home Care Recovery Insurance for:

☐ Member and: ☐ Spouse or ☐ Domestic Partner (Completion of a Declaration of Domestic Partnership will be required)

Complete if enrolling Spouse or Domestic Partner ***Please note additional premium is required.***

Spouse/Domestic Partner Name: _____

Spouse/Domestic Partner Sex: ☐ Male ☐ Female Spouse/Domestic Partner Date of Birth: _____

Spouse/Domestic Partner Social Security #: _____

Please note: Coverage is effective the first day of the month following the date the enrollment form and initial payment are received.

By signing and dating this application, the member **requests** the insurance indicated; understands that this plan will not cover Preexisting Conditions (A Preexisting condition means an Injury, Sickness or Pregnancy or any related condition for which a person consults a doctor, receives medical services or supplies or takes any medication during the six month period immediately before the initial Insurance Date. A Preexisting Condition does not include any such condition after such person has been continuously insured under the Policy for six months.), and the member and any person proposed for insurance **attest** to having read the Fraud Notice indicated below, and to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: _____ **Date**: _____

Fraud Notice: Residents of NY: Any persons who knowingly and with intent to defraud any insurance company or any 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.

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