CSEA Group Sponsored Insurance Programs
c/o Pearl Insurance
13 Airline Drive | Albany, NY 12205
www.cseainsurance.com

180110 Marketing | Office #191

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR NEW YORK RESIDENTS ONLY MEMBERS UNDER AGE 55

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer	Group Customer #	Division	Class	Dept Code	Coverage Effective Date (MM/DD/YYYY)
Civil Service Employees Association (CSEA)	**5050044**				

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)			Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)			Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ Married ☐ Single ☐ Widowed ☐ Divorced	☐ New Enrollment ☐ Change in Enrollment Amount of increase	
Employed By	Occupation / Work Phone #	Date Employed (MM/DD/YYYY)	☐ State ☐ Local Government ☐ Private Sector	

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.

Term Life Insurance

☐ Term Life[1] ☐ $50,000 ☐ $25,000	☐ Dependent Spouse/Domestic Partner [2] Term LIfe[1,3] ☐ $25,000 ☐ $12,500

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner) please provide the information requested below:

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

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

[2] 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

[3] Amounts will be subject to state limits, if applicable.

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FRAUD WARNING

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.

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to Pearl Insurance 13 Airline Dr Albany, NY 12205.

CSEA
LMI-ST111M-NW (12/14)

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

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. I understand that this information will be used by MetLife to determine my insurability.
2. I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

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

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