MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT FORM FOR GROUP TERM LIFE INSURANCE
CIVIL SERVICE EMPLOYEES ASSOCIATION (CSEA) (GROUP CUSTOMER 5050044) - NY RESIDENTS ONLY FOR NEW CSEA MEMBERS UNDER THE AGE OF 70

Marketing | Office #191

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Primary Phone # ☐ Cell ☐ Home ☐ Work	Secondary Phone # ☐ Cell ☐ Home ☐ Work	Date of Hire (MM/DD/YYYY)
Email Address		Work Location

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 [1]
☐ $25,000 ☐ $50,000

☐ Dependent Child [3]
☐ $5,000 ☐ $10,000

☐ Dependent Spouse/Domestic Partner [2] Life [1, 3]
☐ $25,000 ☐ $50,000 The maximum amount of Spouse/Domestic Partner coverage cannot exceed the Member coverage amount.

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

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

_____ _____ ☐ Male ☐ Female

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

[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. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[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 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.

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.

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BENEFICIARY DESIGNATION

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.

☐ 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.

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DEC

SUBMISSION INSTRUCTIONS

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

CSEA
EF-ST111M-NY (08/18)
Agent #_____

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 declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. 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. The requirement that a dependent not be Hospitalized does not apply to newborn children. 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.

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.

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

Members Rates: Bi Weekly Premiums

Benefit Amount	Member Age					
	< 30	30-34	35-39	40-44	45-49	50-54
$25,000	$ 1.15	$1.90	$2.70	$3.75	$5.55	$ 9.00
$50,000	$ 2.30	$3.80	$5.40	$7.50	$11.10	$ 18.00

Spouse Rates: Bi Weekly Premium

Spouses may elect up to 50% of member coverage

(Use member's age to calculate spouse's premium)

Benefit Amount	Member Age					
	< 30	30-34	35-39	40-44	45-49	50-54
$25,000	$ 1.50	$2.10	$2.85	$3.75	$5.55	$ 9.00
$50,000	$ 3.00	$4.20	$5.70	$7.50	$11.10	$ 18.00

Member & spouse premiums are adjusted when the member reaches a new five-year age bracket, with the adjustment made on November 1st, based on the member's age on April 30th of the following year. Rates are subject to change. Coverage reduced at age 70 to lesser of 50% and $25,000.

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.