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

Request For Change/Coverage Increase
CSEA Group Disability Income Insurance

Group Policy # G-11628-0

Name: _____ Social Security #: _____

Address: _____ Dateof Birth: _____

City: _____ State: _____ ZIP _____

Preferred Phone Number: _____ Email: _____

○ Home ○ Cell ○ Work

JOB CLASSIFICATION: Premium change will be effective within 2 to 3 pay pay periods.

☐ **Change my job classification to Office or Clerical Work** ☐ **Non-Office or Non-Clerical Work**

COVERAGE CHANGE REQUEST: I would like to:

☐ **Decrease** my Disability Insurance Monthly Benefit Amount from $_____/mth to $ _____/mth

☐ Change my Disability Insurance **Waiting Period** from _____Days to _____Days

☐ Change my Disability Insurance **Benefit Duration** from _____Mths to _____Mths

☐ **Increase** Optional AD&D coverage ☐ $10,000 ☐ $30,000 ☐ $50,000 ☐ $100,000

☐ **Decrease** my Optional AD&D coverage to ☐ $0 ☐ $10,000 ☐ $30,000 ☐ $50,000
$5,000 AD&D Included with Plan to remain

☐ **Add** Long-Term Accident Benefit ☐ **Remove** Long-Term Accident (LTA) Benefit

☐ **Add** Optional Spouse Accident Disability Benefit ☐ $500 ☐ $1,000 ☐ **Remove** Spouse

Spouse Name: _____ Spouse DOB: _____

☐ **Increase** Optional Spouse Accident Disability Benefit to $1,000 ☐ **Decrease** to $500

☐ **Add** Optional Child Outpatient Emergency Accident Benefit: $50 per child — maximum of two outpatient visits per calendar year per child. (My child/ren is/are under age 19 as of the date of this application.)

I hereby **request** the change indicated above. I declare I am a CSEA Member currently insured in this program and understand that any change requested that requires additional premium will be deducted from my paycheck, provided I am at full time work on that date.

I also understand that reducing a waiting period or increasing a benefit duration is subject to the pre-existing limitation and as a result, 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 six-month period before it is effective, until it has been continuously in force for 12 months.

Signature of Member X _____ Date _____

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Name: _____ Social Security #: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ ZIP _____

Preferred Phone Number: _____ **My Annual Salary:** $ _____

☐ Home Cell ☐ Work

REQUEST FOR COVERAGE INCREASE

I hereby request that my monthly benefit under the **CSEA Disability Income Insurance** be increased by: **$** _____ for a **NEW** total monthly benefit of **$** _____

Under this offer, coverage may not be increased beyond a **$1,300 Monthly Benefit maximum** for Non-Clerical Workers and **$2,000 Monthly Benefit maximum** for Clerical/Office Workers.

Pre-existing conditions may not be covered immediately. See Member Declaration below for further details.

READ AND SIGN

Member Declaration: I hereby **request** the coverage increase as indicated above and **attest** to having read the Fraud Notice below and that to the best of my knowledge and belief, the answers provided to the questions are true and complete. I declare that I am a CSEA Member currently insured in this program. I understand that this coverage increase will be effective on the date the additional premium due is deducted from my paycheck, provided I am at full-time work on that date.

I also understand that any benefit for this increased coverage amount 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 six-month period before it is effective, until it has been continuously in force for 12 months.

Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature **X** _____ Date _____

Please sign, date and send the request form to: Pearl Insurance | 13 Airline Drive | Albany, NY 12205

Sponsored by: CSEA NEW YORK

Administered by: PEARL® INSURANCE