How To Apply For the CSEA Sponsored Disability Income Coverage

(Please note that CSEA membership is required for participation in any of the insurance plans)

1. Be sure to review the plan description for coverage details including eligibility, amounts available, plan options, premium rates, exclusion limitations and renewal premiums, etc.

2. Print these instructions and the application form. Note: This application may be used to request benefits up to $1,000 per month under the Classic Plan. If you are requesting a monthly benefit over $1,000, or, the 6 month or 2 Year Benefit Option you must complete the Regular Application and answer medical questions. (Call Pearl Carroll & Associates for a copy of the Regular Application)

3. Complete the application and payroll deduction authorization form, and mail them to: CSEA Insurance Program, c/o Pearl Carroll & Associates, 12 Cornell Road, Latham, NY 12110. **Make sure you sign and date all forms!**

4. All coverage is subject to underwriting approval and receipt of initial premium payment.

5. If you have any questions or concerns, call Pearl Carroll & Associates toll free at: **1-800-929-6656 - Mon-Fri 8am-5pm or send an e-mail to lenny.ramgulam@PearlCarroll.com.**

Request for Group Insurance from
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
The Company You Keep©

NON-MEDICAL APPLICATION FOR GROUP DISABILITY INCOME/AD&D PLAN FOR CSEA MEMBERS

(PLEASE PRINT IN INK - DO NOT TYPE)

1. MEMBER NAME AND INFORMATION:

LAST ______ FIRST ______ MIDDLE ______

STREET ADDRESS ______

CITY ______ STATE ______ ZIP CODE ______

SOCIAL SECURITY NUMBER ______ HOME PHONE# (____) ______ WORK PHONE# (____) ______

MEMBER'S DATE OF BIRTH: MONTH:____ DAY:____ YEAR:____ SEX: ☐ MALE ☐ FEMALE

2. MEMBERSHIP AFFILIATION - OCCUPATIONAL STATUS:

A. Are you now a member of CSEA? ☐ YES ☐ NO

B. Where are you employed?______ Date employed?______

C. Are you presently performing all the duties of your occupation according to your regular schedule? ☐ YES ☐ NO

D. Are you solely engaged in office or clerical work? ☐ YES ☐ NO

E. What is your annual salary? $ ______

F. Describe your occupation/duties: ______

G. Are you currently insured under the program? ☐ YES ☐ NO

3. INSURANCE REQUESTED - INSURANCE STATUS:

REFER TO BROCHURE FOR ELIGIBILITY, OPTIONS AND COVERAGE DESCRIPTION

I hereby apply for the coverage indicated below based on all my statements made in this application.

You may choose any Monthly Benefit from $300 to $1,000 per month provided it does not exceed the amount shown in the brochure based on your current annual salary.

A. Monthly Benefit: $ ______

B. Waiting Period in Days: ☐ 0 Accident/7 Sickness ☐ 30 Accident/30 Sickness

C. Maximum Benefit Period: ☐ 12 Months ☐ 12 Months with lifetime non-occupational injury benefit

D. Accidental Death and Dismemberment Benefit Option: ☐ $10,000 ☐ $30,000 ☐ $50,000 ☐ $100,000

BENEFICIARY DESIGNATION: I make the following beneficiary designation with respect to AD&D Insurance, and if I am already covered, I revoke any prior beneficiary designation.

BENEFICIARY NAME ______ BENEFICIARY'S RELATIONSHIP TO MEMBER ______ SOCIAL SECURITY # ______

BENEFICIARY'S STREET ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

I request the insurance indicated above. To the best of my knowledge and belief the statements I have made are true and complete. I understand that coverage will be effective on the date approved by New York Life provided the first premium has been paid and I am at full-time work.

I understand that 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 6 month period before my effective date, until my coverage has been continuously in force for 12 months.

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 such violation.

Signature of Member X ______ Date ______

PLEASE SIGN AND DATE IN INK

FOR COMPANY USE ONLY

PLAN	FREQ	PREMIUM TOTALS $	APPROVED BY: