

# CSEA GROUP WHOLE LIFE INSURANCE PLAN APPLICATION

**To Apply, Please Complete and Return to:**  
**CSEA Endorsed Insurance Program Customer Service**  
**P.O. Box 9997**  
**Phoenix, AZ 85068-9997**

**SEND NO MONEY NOW!**  
Payment Handled  
Via Payroll Deduction



California State Employees Association  
Group Whole Life Insurance Plan



Request for Group Insurance from  
New York Life Insurance Co.  
51 Madison Ave., New York, NY 10010

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes. Answer all questions, then sign the Agreement and Authorization below.

## 1. Member Information

1. Member Name:  Member Number:

2. Street Address:

3. City:  State:  Zip:

4. Member SSN:  -  -  5. Email Address:

6. Date of Birth:  /  /  6. Place of Birth:

8. Daytime Phone #: (  )  -  Hire Date:  /  /  Affiliation:  SEIU  CSUEU  ACSS

9. Beneficiary Designation: I hereby make the following beneficiary designation with respect to all the insurance on my life under the Group Accidental Death and Dismemberment Insurance Plan that I select. If I am already covered under the plan, I hereby revoke any prior beneficiary designation. For multiple beneficiaries, contact the Administrator.

Beneficiary Name:

Social Security Number:  -  -  Relation to Member:

10. List below only those individuals applying for coverage:  Spouse  Domestic Partner

Full Name:  Date of Birth:  /  /  Sex:  M  F

Child Name (if proposed for insurance):  Date of Birth:  /  /  Sex:  M  F

## 2. Insurance Requested

### I HEREBY APPLY FOR THE FOLLOWING GROUP WHOLE LIFE INSURANCE COVERAGE:

**A.** I am employed by the State of California for less than 7 (seven) months and qualify for one of the below age brackets:

- |  |  |
|--|--|
| For Members Under 65: <input type="radio"/> \$50,000                 | For Members Over 65: <input type="radio"/> \$ 2,500                  |
| Spouse/Domestic Partner Option: <input type="radio"/> \$ 5,000       | Spouse/Domestic Partner Option: <input type="radio"/> \$ 2,000       |
| Child 14 Days to Under 6 Months Option: <input type="radio"/> \$ 500 | Child 14 Days to Under 6 Months Option: <input type="radio"/> \$ 200 |
| Child 6 Months to Under 26 Option: <input type="radio"/> \$ 5,000    | Child 6 Months to Under 26 Option: <input type="radio"/> \$ 2,000    |

## 3. Authorization and Signature

I hereby enroll for Whole Life coverage offered through the California State Employees Association (CSEA) Insurance Plan provided by New York Life Insurance Company, available to CSEA members. I authorize the State of California to deduct the monthly premium for such Group Insurance from my salary or wages and to pay said premium in accordance with the law. I am a CSEA member in good standing and I am a permanent employee currently working at least 20 hours per week. I understand that coverage will be effective on the first of the month following payroll deduction and receipt of my Application and Payroll Deduction Authorization form by New York Life Insurance Company.

**X**  **X**  /  /   
Member Signature Date (MM/DD/YYYY)

**X**  **X**  /  /   
Spouse Signature (if applying) Date (MM/DD/YYYY)