For California Residents Only. All Other Residents: Call Administrator for Form

SEIU LOCAL 1000 1-YEAR GROUP SHORT-TERM DISABILITY INCOME 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

SEIU Local 1000, an affiliate of the California State Employees Association
1-Year Group Short-Term Disability Income 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 on the last page.

1. Member Information

1. Member Name:
2. Street Address:
3. City: State: Zip:
4. Member SSN: - - 5. Email Address:
6. Date of Birth: / / 7. Daytime Phone #: ( ) - 8. Sex: ○ Male ○ Female
9. Height ft. in. Weight: pounds 10. Member Number: Affiliation: ○ SEIU 1YR
11. Public Employer's Name:
12. Current Occupation / Profession:
13. Please describe your duties:
14. Earning(s) Monthly: $, .
15. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at FULL-TIME WORK? ○ Yes ○ No
16. Do you intend to reside outside the U.S. or Canada in the next 12 months? ○ Yes ○ No If yes, what country?
17. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability, including this plan? ○ Yes ○ No If yes, complete the following:
    Company: Plan: Monthly Benefit: $, . Benefit Period: months/years
18. Beneficiary Designation: I hereby make the following beneficiary designation with respect to all the insurance on my life under the SEIU Local 1000 1-Year Group Short-Term Disability Income Insurance Plan. 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:

2. Insurance Requested

(Please feel free to attach a separate document if you need additional space.)

○ **YES**, I request coverage in the SEIU Local 1000 1-Year Group Short-Term Disability Income Plan:

(Your monthly benefit and premiums are determined by your monthly earnings, and age, and will be payroll deducted for your convenience.)

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3. Statement of Health

To the best of your knowledge and belief, answer the following questions as they apply to you.

A. Are you now taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment? . . . . . ◯ Yes ◯ No

B. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:

1) heart or circulatory trouble; elevated blood pressure; chest pain or pressure; gynecological or genitourinary disorders; disorder of breast or reproductive organs or functions; ulcers or digestive disorders; cancer; tumor or cyst; diabetes; mental or nervous disorder; emotional conditions; psychiatric care or psychotherapeutic treatment; fainting spells; convulsions or epilepsy; respiratory disorder; kidney or liver disorder (including hepatitis); enlarged lymph nodes or immunodeficiency disorder; thyroid disorder; blood disorder; albumin, blood, pus or sugar in urine; back trouble/disorder; arthritis; bone or joint disorder; varicose veins; hemorrhoids or hernia; disorder of eyes, ears, nose or sinuses; unexplained weight loss or accidental injury? . . . . . ◯ Yes ◯ No

2) other health or physical impairment including:

a) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ◯ Yes ◯ No

b) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? . . . . . ◯ Yes ◯ No

c) Any other impairment? . . . . . ◯ Yes ◯ No

C. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs? . . . . . ◯ Yes ◯ No

D. Are you now pregnant? . . . . . ◯ Yes ◯ No

E. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance? . . . . . ◯ Yes ◯ No

F. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing or any type of organized motorized racing? . . . . . ◯ Yes ◯ No

G. Your Driver's License No.: ☐☐☐☐☐☐☐☐☐☐ State issued: ☐☐

H. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations? . . . . . ◯ Yes ◯ No

I. Except for Residents of Minnesota and Connecticut, has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending? . . . . . ◯ Yes ◯ No

J. If you have answered "yes" to any of the previous questions, give complete details in the box below. (Attach a separate sheet if necessary.)

Answers to Health Questions:

Illness or Condition - Date of Onset - Duration - Treatment - Operation - Degree of Recovery and Date	Name and address of Physicians or other Practitioners and Hospitals where confined or treated

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4. Authorization and Signature

Fraud Notice

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 may be a crime and may subject such person to criminal and civil penalties.

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself as stated in the IMPORTANT NOTICE.

I authorize the State of California to deduct the monthly premium for such Group Insurance from my paycheck and to pay said premium in accordance with the law. I am a CSEA Member in good standing and 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 by New York Life Insurance Company.

By signing and dating this application, I requests the insurance indicated, and I consents to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including how my information is exchanged with MIB, and including mailing a brief report of my protected health information to MIB, Inc. I, the member, attest to having read the IMPORTANT NOTICE found in the "Terms tab" on the insurance website, and have read the Fraud Notice indicated above. To the best of my knowledge and belief, the answers I have provided to the questions are true and complete.

X _____ **X** ☐☐/☐☐/☐☐☐☐

Member Signature | Date (MM/DD/YYYY)

Retain a photocopy of this application for your records and return the original to:
CSEA ENDORSED INSURANCE PROGRAM CUSTOMER SERVICE
P.O. BOX 9997, PHOENIX, AZ 85068-9997