CSEA GROUP FINAL EXPENSE 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 Final Expense 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

2. Insurance Requested

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

A. I am employed by the State of California for less than 7 (seven) months:

Member Option: ○ $10,000 ○ $20,000

Spouse/Domestic Partner Option * ○ $10,000 ○ $20,000

*Spouse/Domestic Partner coverage may not exceed Member's Coverage.

3. Authorization and Signature

I hereby enroll for the Group Final Expense 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)

G-30383-0

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

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