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:	○ $50,000	For Members Over 65:	○ $ 2,500
Spouse/Domestic Partner Option:	○ $ 5,000	Spouse/Domestic Partner Option:	○ $ 2,000
Child 14 Days to Under 6 Months Option:	○ $ 500	Child 14 Days to Under 6 Months Option:	○ $ 200
Child 6 Months to Under 26 Option:	○ $ 5,000	Child 6 Months to Under 26 Option:	○ $ 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)

G-30380-0

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

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