Request for Group Insurance from
New York Life Insurance Company
51 Madison Avenue, NY, NY 10010

Applying Is Easy. Here's How:

1. Complete and Sign This Form in Ink.
2. Send No Money Now. You Will Be Billed Once Coverage is Approved.
3. Mail Completed Form to:
   CSEA Benefits Insurance Program
   P.O. Box 9997, Phoenix, AZ 85068-9954

Have a Question or Need Additional Information? Please Call 1-866-340-3924. or visit www.cseabenefitsprogram.com

Group 10-Year Level Term Life Insurance Application

For Members of the California State Employee Association

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.

1 Member's Full Name and Information:

Name _____ (LAST / FIRST / MIDDLE)

Social Security #: ___ - ___ - ____

Home Phone: (___) ___ - ____ (AREA CODE / NUMBER)

Street Address _____

Business Phone: (___) ___ - ____ (AREA CODE / NUMBER)

City _____

State (or Province) _____ Zip Code _____ - ____

E-mail Address _____

Date of Birth/ Mo. Day Yr.: ___ / ___ / ____

Height: ___ ft. ___ in. Weight/ Lbs.: ___ Sex: ☐ M ☐ F

Place of Birth: _____

Member Number: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* or Domestic Partner*

*As applicable only where jurisdictional law so mandates. Call the Administrator for Declaration of Domestic Partnership Form, complete, and return with application.

If married, is your spouse a CSEA Member? ☐ Yes ☐ No

If yes, please provide the full name and social security number of your spouse below.

Spouse Name _____ (LAST / FIRST / MIDDLE) Spouse Social Security #: ___ - ___ - ____

Are you presently insured under any other CSEA Benefits Insurance Programs? ☐ Yes ☐ No

If "Yes," indicate which Insurance(s) and provide details below (person insured and amount of insurance).

☐ TermPLUS Life ☐ Final Expense ☐ Group Whole Life

Details: _____

2 Membership Affiliation

The CSEA Benefits Insurance Program covers members in the following associations. Please check your affiliation(s).

☐ SEIU ☐ ACSS ☐ CSUEU ☐ Retirees

Membership in CSEA or a cooperating society is required for participating in this coverage.

3 Insurance Requested *Refer to brochure for eligibility, options, and coverage description.*

A. I Hereby Apply For the Following Group 10-Year Level Term Life Insurance Coverage:

Member ☐ Insurance Requested: $ ___,___.___.

Spouse /Domestic Partner* ☐ Insurance Requested: $ ___,___.___. *Spouse coverage cannot exceed member's coverage.

☐ **Spouse** or** ☐ **Domestic Partner****

_____ (Name if Proposed for Insurance) ___ / ___ / ____ (Date of Birth/Mo. Day Yr.) ___ ft. ___ in. (Height) ___ (Weight/Lbs.) ☐ M ☐ F (Sex)

**See Coverage Information for definition of eligible dependents.

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member ☐ Yes ☐ No Country(ies) _____ Spouse /Domestic Partner ☐ Yes ☐ No Country(ies) _____

B. Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any Member Spouse nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

	Member	**Spouse / Domestic Partner**
	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: ___ / ____ (MM/YYYY) _____ (Product) Spouse: ___ / ____ (MM/YYYY) _____ (Product)

Continued next page.

3 Insurance Requested (Continued) *Refer to brochure for eligibility, options, and coverage description.*

C. Insurance Replacement **Member** **Spouse**

Is the insurance applied for intended to replace, discontinue, or change an existing policy? ☐ Yes ☐ No ☐ Yes ☐ No

Do you have other life insurance in force? If "Yes," total amount in all companies: Member $,

Spouse $,

D. Do you have other life insurance applications pending? ☐ Yes ☐ No If "Yes," indicate amount and company:

Member: $, Company

Spouse: $, Company

4 Beneficiary Designation *Insert name, relationship, and address*

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group 10-Year Level Term Life Insurance and, if I am already covered under the policy, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, please note if each is to be primary and/or secondary, and also indicate the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

☐ Primary ☐ Secondary % _____

Beneficiary Name _____

Beneficiary's Relationship to Member

Beneficiary's Date of Birth _____

Beneficiary's Social Security # _____

Street Address _____

City _____

State _____ Zip Code _____

Beneficiary's Phone Number _____

☐ Primary ☐ Secondary % _____

Beneficiary Name _____

Beneficiary's Relationship to Member _____

Beneficiary's Date of Birth _____

Beneficiary's Social Security # _____

Street Address _____

City _____

State _____ Zip Code _____

Beneficiary's Phone Number _____

5 Statement of Health *(Please initial and date any changes you make to this form)*

To the best of your knowledge and belief, please answer the following questions as they apply to you and all dependents to be insured. **Yes** **No**

A. Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance? ☐ ☐

B. Are you or any other person to be insured now ill or receiving medical attention or surgical treatment? ☐ ☐

C. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or check up, or been hospitalized or had an operation or had any illness, disease, or injury? ☐ ☐

D. Are you or any person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ ☐

E. Is any person to be insured now pregnant? ☐ ☐

F. During the past five years, has any person to be insured ever been medically diagnosed by a physician or been treated for: ☐ ☐

	Yes	No
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐
2. Arthritis, back trouble, bone or joint disorder?	☐	☐
3. Fainting spells, convulsions, or epilepsy?	☐	☐
4. Sugar, blood, albumin, or pus in urine?	☐	☐
5. Diabetes, kidney trouble, ulcers, or digestive disorder?	☐	☐
6. Disorder of breasts or reproductive organs or functions?	☐	☐
7. Nervous or mental disorder, emotional condition, or psychiatric care?	☐	☐
8. Cancer, tumor, or cyst?	☐	☐
9. Varicose veins, hemorrhoids, or hernia?	☐	☐
10. Disorder of eyes, ears, nose, or sinuses?	☐	☐
11. Thyroid, liver, or respiratory disorder?	☐	☐
12. Alcoholism or drug habit?	☐	☐
13. Disorder of the blood?	☐	☐
14. Other health or physical impairment including:		
(i). Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	☐	☐
(ii). Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	☐	☐
(iii). Any other impairment?	☐	☐

G. Have you or has your spouse (if proposed for insurance), had a parent, brother, or sister who, prior to age 60, was medically diagnosed by a physician as having, or being treated for, cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, or neuromuscular, or mental illness? ☐ ☐

H. Within the past two years have you or has your spouse (if proposed for insurance) participated in, or do either of you within the next two years plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, organized motorcycle racing, rodeo riding, snowmobiling, any type of motorized racing, hang-gliding, parasailing, or bungee jumping? ☐ ☐

I. Driver's License No.: Member _____ Spouse _____

State in Which Issued: Member _____ Spouse _____

J. Have you or has your spouse (if proposed for insurance) had driver's license suspended or revoked, or had any moving violations, within the past five years? ☐ ☐

IF YOU HAVE ANSWERED ANY QUESTIONS 'YES,' GIVE COMPLETE DETAILS BELOW:

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various," or "miscellaneous.")

Question Letter/No.	Name(s) of Proposed Insured	Illness or Condition—Date of Onset—Duration—Treatment—Operations—Degree of Recovery and Date	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated

FRAUD NOTICE

FOR RESIDENTS OF CA: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AUTHORIZATION AND SIGNATURE:

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, 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.

I authorize the State of California to deduct the monthly premium for such Group Insurance from my paycheck or pay warrant to pay said premium in accordance with the law. I am a CSEA Member in good standing. 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, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE below and Fraud Notice indicated above, including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature **X** _____ Today's Date ☐☐ / ☐☐ / ☐☐☐☐

(PLEASE SIGN AND DATE IN INK) MM/DD/YYYY

Spouse's Signature **X** _____ Today's Date ☐☐ / ☐☐ / ☐☐☐☐

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) MM/DD/YYYY

[DEFAULT]

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For Group TermPLUS Life Insurance In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company. Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law. New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision. New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved. If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with nonmedical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901 (TTY 866 346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

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