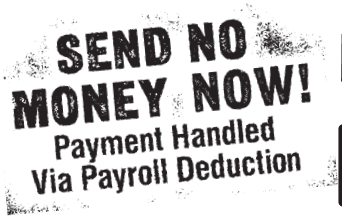
CSEA GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ENROLLMENT FORM

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



California State Employees Association
Group Accidental Death and Dismemberment Insurance

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

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

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. Member Number: Affiliation: ◯ SEIU 59729 ◯ CSUEU 59730 ◯ ACSS 59731
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 coverage that I select. If I am already covered, I hereby revoke any prior beneficiary designation. For multiple beneficiaries, contact the Administrator.

Beneficiary Name:

Social Security Number: - - Relation to Member:

2. Insurance Requested

YES, please enroll me in the selected Accidental Death & Dismemberment Insurance.

Choose your level - fill in one circle:

$500,000.00 Cash Benefit:	◯ Member Only	◯ Family* Plan
$300,000.00 Cash Benefit:	◯ Member Only	◯ Family* Plan
$100,000.00 Cash Benefit:	◯ Member Only	◯ Family* Plan

If Family coverage selected above, please complete the following:

Spouse Name: Date of Birth: / /

Child Name: Date of Birth: / /

*Family refers to "eligible dependents".

3. 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.

4. Authorization and Signature

I hereby enroll for coverage offered through the California State Employees Association (CSEA) Insurance 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 Member Signature

X / / Today's Date (MM/DD/YYYY)

Licensed agent of record number 0F70947

G-29148-0

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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ed: 7/2022
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