CSEA GROUP TERMPLUS LIFE INSURANCE APPLICATION

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

GUARANTEED ISSUE:
SEND NO MONEY NOW!
Payment Handled Via Payroll Deduction

California State Employees Association
Group TermPLUS Life 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: 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 Termplus Life Insurance that I select. If I am already covered under the coverage, 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 TERMPLUS LIFE INSURANCE COVERAGE:

A. I am employed by the State of California for less than 7 (seven) months and fall under the following Gross Monthly Income Bracket:

Please select your monthly Income Bracket →	○ Less than $1,800	○ $1,800 to $2,499.99	○ $2,500 or more
Please Select One Guaranteed Coverage Amount for which You Are Eligible →	○ $25,000 ○ $50,000	○ $25,000 ○ $50,000 ○ $75,000	○ $25,000 ○ $50,000 ○ $75,000 ○ $100,000

Spouse/Domestic Partner Option: ○ $20,000
Child Option: ○ $10,000

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 TermPLUS Life 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.

Member Signature **X** Today's Date (MM/DD/YYYY) **X** / /

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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