California State Employees Associate
Group TermPLUS Life Insurance

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

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

GROUP TERMPLUS LIFE INSURANCE

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER INFORMATION

Full Name (First, Middle, Last) ____ Social Security Number ___-___-____

Member Number ____ Date of Birth __/__/__ Place of Birth ____

Street Address ____ City ____ State ____ ZIP ____

Home Phone (___)___-____ Work Phone (___)___-____ Fax Number (___)___-____

Email (For internal use only. Email address will never be sold or shared.) ____ Date of Hire __/__/__

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* ◯ Domestic Partner* 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 (First, Middle, Last) ____ Social Security Number ___-___-____

*Eligibility of Domestic Partner/Civil Union is determined by State Law.

Are you currently insured under any other CSEA life plan? ◯ Yes ◯ No If "Yes" indicate which plan(s) and provide details below:

◯ Group Whole Life ◯ 10-Year Level Term Life ◯ Final Expense Person Insured _____ Amount $ _____

LIST BELOW ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Member (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
◯ Spouse ◯ Domestic Partner (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
Child*** (Name if proposed for Insurance):	/ /	ft. in.	LBS.	◯ M ◯ F
Child*** (Name if proposed for Insurance):	/ /	ft. in.	LBS.	◯ M ◯ F

***See plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

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

Member/Employee: ◯ Yes ◯ No Country(ies) _____ How Long? _____

Spouse/Domestic Partner: ◯ Yes ◯ No Country(ies) _____ How Long? _____

2. MEMBERSHIP AFFILIATION

A. Membership is required to obtain coverage. Affiliation: ◯ SEIU ◯ CSUEU ◯ ACSS ◯ Retirees

3. INSURANCE REQUESTED: Refer to plan information for eligibility, principal sums, premium, and coverage description.

A. **I HEREBY APPLY FOR THE FOLLOWING GROUP TERM PLUS LIFE INSURANCE COVERAGE**

Member Option: **Insurance Requested: $** _____ Spouse/Domestic Partner Option: **Insurance Requested: $** _____

Child Option: ◯ **$5,000** ◯ **$10,000**

B. **INSURANCE REPLACEMENT**

ALL RESIDENTS:

Is the insurance applied for intended to replace, discontinue, or change an existing policy? Member/Employee: ◯ Yes ◯ NO Spouse/Domestic Partner: ◯ Yes ◯ NO

Do you have other insurance in force? If "Yes," total amount in all companies Member: _____ Amount/Company Spouse/Domestic Partner: _____ Amount/Company

Be sure to complete both pages and sign the last page

4. BENEFICIARY DESIGNATION: Insert name, relationship, and Social Security Number

I make the following beneficiary designation with respect to all the insurance on my life under this Group TermPLUS Life Insurance Plan and if I am already covered under the plan, 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 want to name a different beneficiary for spouse/domestic partner coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.) (1) In naming more than one beneficiary, please note if each is to be primary and/or secondary, and 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.)

Beneficiary Name (Last, First, Middle Initial)

Street Address | City | State | Zip

Relationship to Proposed Insured | Date of Birth (MM/DD/YYYY) | Social Security Number | Phone

5. MEMBER STATEMENT OF HEALTH:

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

		MEMBER	SPOUSE/DOMESTIC PARTNER
A.	Is any person proposed for insurance now ill, receiving or considering medical attention or treatment, or considering surgery?	☐ Yes ☐ No	☐ Yes ☐ No
B.	Within the last five years, has any person proposed for insurance been counseled, hospitalized, or treated for: (a) using alcohol or drugs; or (b) mental, emotional, or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
C.	Within the last five years, has any person proposed for insurance been diagnosed by a physician as having, or been treated for: heart trouble, elevated blood pressure, cancer, diabetes, epilepsy, neurological or respiratory disorder, kidney or liver disorder, pancreas disorder, enlarged lymph nodes or tumors, disorder of the circulatory or digestive system, gynecological or genitourinary disorders, immunodeficiency or blood disorder, or unexplained weight loss?	☐ Yes ☐ No	☐ Yes ☐ No
D.	Have you or your spouse/domestic partner (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes," please state when you last used tobacco or nicotine and specify the product. Member _____ Spouse/Domestic Partner _____

If you answered "Yes" to any of the questions above, please give details below and on additional sheets if needed.

NATURE OF ILLNESS, INJURY, OR OPERATION	DATES OF TREATMENT	REMAINING EFFECTS	NAME AND ADDRESS OF DOCTOR/HOSPITALS

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history. What time and telephone number would be best to contact you?

_____ ◯ AM ◯ PM ( ) -
Time Phone

6. 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.

7. 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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, 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 as stated in the IMPORTANT NOTICE. **I authorize the State of California to deduct the monthly premium for such Group Insurance from my pay check 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 mailing a brief report of my protected health information to MIB, Inc, and attest to having read the IMPORTANT NOTICE on the following page and Fraud Notices indicated above, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

_____ / / **Member's Signature** (Please sign and Date in ink) **Today's Date** (MM/DD/YYYY)

_____ / / **Spouse/Domestic Partner's Signature** (Necessary Only if Spouse Coverage is Requested) **Today's Date** (MM/DD/YYYY)

DO NOT SEND PAYMENT: Upon approval, your premium will be deducted from your paycheck via payroll deduction.

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.

New York Life Insurance Company **6/15 ed.**