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

Request to New York Life Insurance Company for Group Hospital & Home Care Recovery Insurance

Guaranteed Issue Offer Application

Name: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____

Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Date of Birth: _____ **Social Security #**: _____

Sex: ☐ Male ☐ Female **Marital Status**: ☐ Married ☐ Single ☐ Domestic Partnership

INSURANCE REQUESTED: (refer to brochure for eligibility and coverage description)

I hereby apply for Hospital & Home Care Recovery Insurance for:

☐ Member and: ☐ Spouse or ☐ Domestic Partner

Complete if enrolling Spouse or Domestic Partner ***Please note additional premium is required.***

Spouse/Domestic Partner Name: _____

Spouse/Domestic Partner Sex: ☐ Male ☐ Female Spouse/Domestic Partner Date of Birth: _____

Spouse/Domestic Partner Social Security #: _____

Please note: Coverage is effective the first day of the month following the date the applocation and initial payment are received.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

By signing and dating this application, the member **requests** the insurance indicated; understands that this plan will not cover Pre-existing Conditions (A Pre-existing condition means an Injury, Sickness or Pregnancy or any related condition for which a person consults a doctor, receives medical services or supplies or takes any medication during the six month period immediately before the initial Insurance Date. A Preexisting Condition does not include any such condition after such person has been continuously insured under the Policy for six months.), and the member and any person proposed for insurance **attest** to having read the Fraud Notice indicated below, and to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: _____ **Date**: _____

Fraud Notice: **Residents of NY**: Any persons who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, informa-tion concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Payroll Deduction Authority for CSEA Membership

CSEA, Local 1000 AFSCME, AFL-CIO
143 Washington Avenue, Albany, New York 12210 | Phone: 1-800-342-4146, x1314 • Fax: 518-465-2382

I hereby authorize the Civil Service Employees Association, Inc. (CSEA), Local 1000 AFSCME, AFL-CIO, to be my exclusive representative for collective bargaining and therefore revoke any other representative that I may have previously designated. I also hereby authorize the fiscal or payroll officer of my employer to deduct CSEA dues from my salary in the amount certified by CSEA in this and succeeding years of my employment and membership.

Dues, contributions or gifts to CSEA are not tax deductible as charitable contributions. However, they may be deductible as ordinary and necessary business expenses. I may revoke this authorization by sending a letter stating my intent to resign, along with my name, address, telephone number, and CSEA ID number, by United States Postal Service First Class Mail to: CSEA Statewide Secretary, Civil Service Employees Association, Inc., 143 Washington Avenue, Albany, N.Y. 12210.

TO THE FISCAL OFFICER OF MY EMPLOYER: I am a member of, or have applied for membership in, CSEA and thereby authorize you to deduct from my salary each payroll period the necessary amounts for payment of CSEA Membership Dues and insurance premiums (check applicable boxes, if any):

☐ TERM LIFE ☐ WHOLE/UNIVERSAL LIFE ☐ DISABILITY ☐ CAP ☐ CRITICAL ILLNESS ☐ HHCR ☐ AUTO/HOME

☐ CHECK BOX IF YOU ARE A VETERAN

SALUTATION | MR. ☐ MRS. ☐ MS. ☐ MISS

_____
FIRST NAME MI LAST NAME

NICKNAME _____

MAILING ADDRESS _____
STREET ADDRESS

_____
CITY STATE ZIP

PHONE _____
AREA CODE

LISTED UNLISTED

PHONE _____
AREA CODE

DATE OF BIRTH _____
mm dd yyyy

HOME E-MAIL _____
DO NOT GIVE YOUR WORK EMAIL ADDRESS.

NAME OF CSEA LOCAL _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____
NAME OF AGENCY/FACILITY

WORK ADDRESS _____
STREET ADDRESS

_____
CITY STATE ZIP

WORK PHONE _____
AREA CODE

JOB TITLE _____

ANNUAL SALARY _____

Signature: _____ Date: _____

☐ By checking this box I consent to receive calls (including recorded or autodialed calls or texts) at my cell phone number from CSEA and its affiliated labor organizations on any subject matter. You may modify your preferences by calling CSEA at 1-800-342-4146 or visiting the CSEA website at cseany.org.

CSEA OFFICE USE ONLY