CSEA Retiree Insurance Program
c/o Pearl Insurance | cseainsurance.com
1.888.507.1368 | *Enjoy Life. We Got This.*

Simply complete the attached application and payment option form in the fields specified and sign!

You have 3 easy payment options as described below.

Please note that to begin coverage, and with all payment options, we first require a downpayment with your signed and dated application(s). Your initial payment will depend on the billing option.

- **OPTION 1: Electronic Funds Transfer (EFT)** - With Electronic Funds Transfer (EFT), you authorize your bank or financial institution to automatically deduct your monthly insurance premiums from your checking account.

- **OPTION 2: Direct Bill Sent to Your Home** - You may opt to have a bill sent to your home based on the billing cycle you choose: Quarterly, Semi-Annually or Annually.

- **OPTION 3: Pension Deduction** - You may opt to have your payments deducted from your New York State pension. Please note that if you are a new retiree not yet receiving a pension, you will be placed on direct bill for the first 5 months until pension deductions can begin.

Please mail your completed application and down payment to:

Pearl Insurance
13 Airline Drive
Albany, NY 12210

All paperwork and down payments must be received by the 14th of the month for coverage to become effective on the 1st of the following month.

You must be a CSEA Retiree Member to enroll in any of the CSEA Retiree Insurance Programs. If you are not currently a Retiree Member, contact CSEA at 1-800-342-4146.

The CSEA Group Sponsored Insurance Program has been protecting CSEA Members and their families for over 80 years. Helping people is at the heart of what we do.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

CSEA | PEARL INSURANCE

CSEA Group Sponsored Insurance Program

CHOICE 1 • ENROLLMENT • CHANGE FORM FOR RETIREE DENTAL

Agent 191

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Association	Group Customer #
Civil Service Employees Association (CSEA)	05050023

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female	☐ Single ☐ Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Dental Insurance

Select your level of coverage

- ☐ Member Only
- ☐ Member + One Dependent (Spouse/Domestic Partner[1] or Child)
- ☐ Member + Two or More Dependents (Spouse/Domestic Partner[1] and Children)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

Payment Information

Select the method of payment

- ☐ Monthly ACH automatic deduction from checking account (please complete withdrawal form)
- ☐ Monthly automatic deduction from my pension account (please complete withdrawal form)
- ☐ Direct Bill sent to your home:
  - ☐ Quarterly ☐ Semiannually ☐ Annually

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

GEF02-1
ADM
(*The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original
to Pearl Insurance, 13 Airline Drive Albany, NY 12205
Toll-free phone: 1-888-507-1368

Metropolitan Life Insurance Company, New York, NY 10166

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued. Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties. New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application of files a claim containing a false or deceptive statement may have violated the state law. Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
FW *applies to residents of North Dakota and Utah)*

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I authorize Civil Service Employees Association (CSEA) to deduct the required contributions for my coverage as outlined in the Payment Information section. This authorization applies to such coverage until I rescind it in writing.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

CSEA Voluntary Dental Program

Choice 1 | Metlife Dental

Applicants for Choice 1 are free to use any Dentist.
Using a Preferred Dental Provider will save you money.

CHOICE 1 MONTHLY RATES (All States)
Rates effective through December 31st, 2025

Member: $30.99

Member + 1 (spouse or child): 58.25

Family: $101.64

CHOICE 1 Down Payment for EFT or Pension Deduction

Member: $61.98

Member + 1 (spouse or child): $116.60

Family: $203.28

CHOICE 1 Down Payment Amounts for Direct Bill

Quarterly: Submit 3 months premium

Semi-Annual: Submit 6 months premium

Annual: Submit 12 months premium

PEARL® INSURANCE

Payment Options for Metlife Dental

You have three easy payment options as described below. **Please note that to begin coverage, and with all payment options, we first require payment with your signed and dated application.** Specific payment requirements for each payment option are listed below.

OPTION 1: Electronic Funds Transfer (EFT)

With Electronic Funds Transfer (EFT), you authorize your bank or financial institution to automatically deduct your monthly insurance premiums from your checking account.

Automatic withdrawals

- All withdrawals authorized will appear on your bank statement as "Pearl Insurance."
- Withdrawals will be taken on the first business day of the month.
- If your account does not have enough money, your bank may charge you for insufficient funds when we try to withdraw your payment. We will try to withdraw the money up to two times. If we are unsuccessful, we will notify you by mail of the missed payment and you may risk cancellation of the payment plan.
- If you cancel your policy before the current month's withdrawal date, we will notify you by mail of any balance due.

✓ **PAYMENT REQUIREMENT FOR EFT: First 2 months premium for initial payment.**

OPTION 2: Direct Bill Sent to Your Home

You may opt to have a bill sent to your home based on the billing cycle you choose: Quarterly, Semi-Annually, or Annually.

✓ **PAYMENT REQUIREMENT: Your payment will depend on the billing cycle you choose.**

- For quarterly billing, please include 3 months premium.
- For semi-annual billing, please include 6 months premium.
- For annual billing, please include 12 months premium.

OPTION 3: Pension Deduction

You may opt to have your payments deducted from your New York State pension. **Please note that if you are a new retiree not yet receiving a pension, you will be placed on direct bill for the first 5 months until pension deductions can begin.**

✓ **PAYMENT REQUIREMENT: First 2 months premium for initial payment.**

Effective Date Rules:
Application received prior to 15th of the month: Effective date = 1st of next month
After 15th of the month: Effective date = 1st of month after next

POLICYHOLDER INFORMATION *Please print*

Insured's Name (First, MI, Last Name) | **Email Address**

Home Address (Street, City, State, Zip) | **Daytime Phone**

✓ **OPTION 1: Electronic Funds Transfer (EFT)** If you choose to have your monthly premium deducted from your bank account, please complete below with your banking information.

Bank Routing Number | Bank Account Number

Bank Name
(if different than Policyholder) | Bank Account Owner's Name

AUTHORIZATION & SIGNATURE: I certify that I am the owner and/or authorized signer for this bank account, and I authorize Pearl Insurance NY ("Pearl Insurance") to make electronic debit entries for payment of insurance premiums for my policy(ies) from this account. The entries shall constitute my receipt for the transactions(s). I also understand that if corrections of the entry are necessary, it may involve an adjustment to my account. I recognize that this authorization allows Pearl Insurance to adjust my scheduled deductions to reflect any premium changes. I understand that it is my responsibility to make sure that there are sufficient funds in this account at the monthly withdrawal date. I also understand that the policy(ies) may cancel or expire if there are insufficient funds in the account, pursuant to the terms of the policy(ies). This authorization is to remain in effect until Pearl Insurance receives written notification of its termination and has sufficient time to act on it.

Bank Account Owner's Signature | **Date**

✓ **Option 2: Direct Bill** If you choose to have your bill sent to your home, please select your billing cycle. Your initial premium payment will depend on the billing cycle you choose.

CHECK ONE: ☐ Quarterly Bill ☐ Semi-Annual Bill ☐ Annual Bill

Member Signature | **Date**

✓ **Option 3: Pension Deduction** If you choose to have your monthly premium deducted from your New York State Pension check, (your Pension Deductions will begin after the first 2 months) and sign the Pension Deduction Authorization below.

Pension Deduction Authorization: Pursuant to Section 110-c and 410c of the Retirement and Social Security Law, I hereby authorize deductions to be made from my monthly allowance from the New York State and Local Employees Retirement Systems in the amount necessary to cover membership dues and insurance on my behalf to CSEA, Local 1000, AFSCME, AFL-CIO. Authorization is also given to make any changes the Union certifies to the Retirement System as necessary in the amount of such dues and insurances. I, the undersigned, do hereby authorize you to deduct from my monthly allowance the amount of $3.00 for payment of dues, or any amount as may be certified to you by the Union as my dues and or insurance. I understand that CSEA, Local 1000, AFSCME, AFL-CIO is my agent and all request to begin, modify, or revoke deductions must be submitted through the Union. This authorization shall remain in effect until revoked by me by written notice through the Union or until otherwise revoked pursuant to law.

Pensioner Signature | **Date**

NYSLRS ID # (Required number printed on pension check) | **Pensioner SSN#**