



Request for Group Insurance from  
New York Life Insurance Company  
51 Madison Avenue  
New York, NY 10010  
The Company You Keep®

SOURCE CODE: 110109

Agent #: \_\_\_\_\_

# BASIC PLAN: Non-Medical Application for Group Disability Income/AD&D Plan for CSEA Members

## 1. MEMBER NAME AND INFORMATION:

(PLEASE PRINT IN INK - DO NOT TYPE)

LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ HOME PHONE#: ( \_\_\_\_\_ ) \_\_\_\_\_ WORK PHONE#: ( \_\_\_\_\_ ) \_\_\_\_\_

MEMBER'S DATE OF BIRTH: MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_ SEX:  MALE  FEMALE

## 2. MEMBERSHIP AFFILIATION - OCCUPATIONAL STATUS:

- A. Are you now a member of CSEA?..... YES  NO
- B. Where are you employed? \_\_\_\_\_ Date employed? \_\_\_\_\_
- C. Are you presently performing all the duties of your occupation according to your regular schedule?..... YES ..... NO
- D. Are you solely engaged in office or clerical work? ..... YES  NO
- E. What is your annual salary?.....\$ \_\_\_\_\_
- F. Describe your occupation/duties: \_\_\_\_\_
- G. Are you currently insured under the program? ..... YES  NO

## 3. INSURANCE REQUESTED - INSURANCE STATUS: REFER TO BROCHURE FOR ELIGIBILITY OPTIONS AND COVERAGE DESCRIPTION

I hereby apply for the coverage indicated below based upon all my statements made in this application.  
**You may choose any Monthly Benefit from \$300 to \$1,200 per month provided it does not exceed the amount shown in the brochure based on your current annual salary.**

- A. Monthly Benefit: \$ \_\_\_\_\_
- B. Waiting Period in Days:  0 Accident/7 Sickness  30 Accident/30 Sickness
- C. Maximum Benefit Period:  6 Months
- D. Accidental Death and Dismemberment Benefit Option:  \$10,000  \$30,000  \$50,000  \$100,000

**BENEFICIARY DESIGNATION:** I make the following beneficiary designation with respect to AD&D Insurance, and if I am already covered, I revoke any prior beneficiary designation.

BENEFICIARY NAME: \_\_\_\_\_ BENEFICIARY'S RELATIONSHIP TO MEMBER: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

BENEFICIARY'S STREET ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

I request the insurance indicated above. To the best of my knowledge and belief the statements I have made are true and complete. I understand that coverage will be effective on the date approved by New York Life provided the first premium has been paid and I am at full-time work.

I understand that benefits will not be payable for any condition for which medical advice was given, or treatment was recommended by or received from a physician during the 6 month period before my effective date, until my coverage has been continuously in force for 12 months.

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 such violation.

Signature of Member: X \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE SIGN AND DATE IN INK

PLAN	FREQ	PREMIUM TOTALS \$:	APPROVED BY:
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