

Request for Insurance from:



New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
The Company You Keep®

GROUP WHOLE LIFE INSURANCE PLAN

For CSEA Members

1. MEMBER NAME AND INFORMATION:

LAST: _____ MIDDLE: _____ FIRST: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SOCIAL SECURITY #: _____

HOME PHONE#: _____ WORK PHONE#: _____

MEMBER'S DATE OF BIRTH: _____ / _____ / _____ HEIGHT: _____ FEET _____ INCHES WEIGHT: _____ POUNDS 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? _____

3. DEPENDENT INFORMATION:

Complete only if you are requesting Dependents Coverage. If you need more space attach a separate sheet.

<input type="checkbox"/> Spouse, <i>or</i>	Date of Birth	Sex	Height	Weight
<input type="checkbox"/> Domestic partner: _____	_____ / _____ / _____	<input type="checkbox"/> F <input type="checkbox"/> M	_____ FT _____ IN	_____ LBS
(Name if proposed for insurance)				
Child(ren): _____	_____ / _____ / _____	<input type="checkbox"/> F <input type="checkbox"/> M		
(Name if proposed for insurance)				
_____	_____ / _____ / _____	<input type="checkbox"/> F <input type="checkbox"/> M		
(Name if proposed for insurance)				
_____	_____ / _____ / _____	<input type="checkbox"/> F <input type="checkbox"/> M		
(Name if proposed for insurance)				

4. INSURANCE REQUESTED - INSURANCE STATUS:

Refer to brochure for eligibility, options, and coverage descriptions. Please note that the Accelerated Death Benefits may be payable under this Plan. Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. Prior to applying for accelerated death benefits you should consult with the appropriate social services agency and assistance should be sought from a qualified personal tax advisor.

A. I HEREBY REQUEST THE FOLLOWING COVERAGE:

• **Variable Coverage Amounts** - Member and Spouse/Domestic Partner Coverage Amounts from \$10,000 to \$100,000 in \$10,000 units.
 Member Coverage Amount: \$ _____ Spouse/Domestic Partner Coverage Amount*: \$ _____
 *Spouse's/Domestic Partner's Coverage Amount cannot exceed Member's Coverage Amount

• **Children Coverage Amount** from \$4,000 to \$20,000 for each child in \$4,000 units.

Child's Name	Amount	Child's Name	Amount
_____	\$ _____	_____	\$ _____
_____	\$ _____	_____	\$ _____

• **Payment Mode:** Bi-Weekly Quarterly Annual Other _____

- B. Accidental Death Benefit Option (CHECK ONE): YES NO
 If YES; *Accidental Death Option will apply to both Member and Spouse/Domestic Partner Coverage. Accidental Death Benefit Option is not available on Child Coverage.*
- C. Please answer the following question if you are requesting non-smoker premium rates:
 Have you used tobacco or nicotine in any form in the last 12 months? YES NO
 Has your Spouse/Domestic Partner used tobacco or nicotine in any form in the last 12 months? YES NO

Insurance Replacement

RESIDENTS OF NEW YORK - IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value, by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help decide whether the replacement is in your best interest.

INSURANCE QUESTION - I have read the Important Replacement Information above.

Is the Insurance applied for intended to replace, in whole or part, any existing insurance or annuity?
 Member: YES NO Spouse/Domestic Partner: YES NO

5. BENEFICIARY DESIGNATION:

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Whole Life Insurance Plan. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy.

BENEFICIARY NAME	BENEFICIARY'S RELATIONSHIP TO MEMBER	BENEFICIARY'S SOCIAL SECURITY #
_____	_____	_____
BENEFICIARY'S STREET ADDRESS	CITY	STATE
_____	_____	_____
		ZIP CODE

NOTE: Contact the Plan Administrator if you desire to name a Secondary Beneficiary or, if you wish to designate a specific Beneficiary for your spouse/domestic partner and/or children's coverage.

BE SURE TO COMPLETE AND SIGN REVERSE SIDE

6. STATEMENT OF HEALTH:

(Please initial any changes you make on this form)

Answer the following questions as they apply to you and your spouse/domestic partner (if also proposed for insurance)

- A. Is any person proposed for insurance now disabled or eligible for any disability or workers' compensation benefits or are you on waiver of premium for life or health insurance? YES NO
- B. Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? YES NO
- C. Has any person proposed for insurance ever been diagnosed as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, tuberculosis, liver disorders (including hepatitis), asthma or emphysema, enlarged lymph nodes or immunodeficiency disorder (excluding HIV or AIDS), albumin, blood or sugar in urine, back trouble/disorder, unexplained weight loss in the past twelve months, or other illness, disease or injury? YES NO
- D. During the past 5 years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs? YES NO
- E. During the past 5 years has any person proposed for insurance consulted any physician, chiropractor, medical care practitioner *other than* for a routine physical examination or checkup, or been confined or treated in any hospital, rest home or similar institution? YES NO
- F. If a consultation with a physician was for a routine or annual examination or checkup, were there any symptoms or adverse findings? YES NO

If any answer to items 6A - 6F is YES, give full details below:

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various" or "miscellaneous".)

Questions A-F	Person to Whom It Applies	Date	Names, Addresses, and Phone Numbers of Physicians and Hospitals (If Any)	Include All Information as to the Nature of Illness or Injury. Symptoms, Number of Attacks, Duration, Treatment and Results.

I request the group insurance shown on the reverse side. I understand that insurance will become effective on the date coverage is approved by New York Life, provided the premium is paid and I and any approved dependents are actively performing the normal activities of a person in good health of like age. I understand that any person who was not performing his or her normal activities on the day the premium is paid, will not become insured until the date he or she is performing such activities provided such date is within three months of the date the premium is paid and the person is still eligible for insurance. I also understand that this application is to be attached to and made part of the certificate.

To the best of my knowledge and belief, I am eligible for insurance and the statements I have made are true and complete. I understand that New York Life may: (a) require more information and a medical exam; and (b) invalidate coverage if it finds during the first two years the policy is in force during my lifetime, that I have not answered any of the above questions truthfully and completely. In order to determine insurability, I ask New York Life to rely on all statements made on this form, and any supplements to it, and I authorize disclosure of the types of information detailed in the AUTHORIZATION below. I have read the IMPORTANT NOTICE which describes how New York Life underwrites this request.

AUTHORIZATION: I authorize the release of information to New York Life Insurance Company, its subsidiaries or the Plan Administrator, about the health of any persons proposed for insurance including significant history, findings, diagnosis and treatment by any physician, medical practitioner, hospital, medical or medically related facility, or insurance company. New York Life and its Subsidiaries may release to the Plan Administrator, other insurance companies and to others I authorize in writing, information covered by this AUTHORIZATION. This AUTHORIZATION may be used for a period of two years from either the date signed above or the effective date of coverage, whichever is later. A photocopy of this request shall be as valid as the original. I know that I may request a copy of this AUTHORIZATION.

MEMBER'S SIGNATURE: X _____ **DATE:** _____
 (PLEASE SIGN IN INK USING FULL NAME)

To the best of my knowledge and belief the statements made regarding my health are true and complete.

SPOUSE'S OR DOMESTIC PARTNER'S SIGNATURE: X _____ **DATE:** _____
 (NECESSARY ONLY IF SPOUSE/DOMESTIC PARTNER COVERAGE IS REQUESTED. PLEASE SIGN IN INK USING FULL NAME)