CALIFORNIA STATE RETIREES GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PLAN ENROLLMENT FORM

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

SEND NO MONEY NOW!
Payment Handled Via Payroll Deduction

California State Retirees, an affiliate of California State Employees Association, Group Accidental Death and Dismemberment Insurance Plan

Request for Group Insurance from
New York Life Insurance Co.
51 Madison Ave., New York, NY 10010

Please print in INK. Do not erase or use correction fluid. To correct, cross out and initial/date changes. Answer all questions, then sign the Agreement and Authorization below.

1. Member Information

1. Member Name:
2. Street Address:
3. City: State: Zip:
4. Member SSN: - - 5. Email Address:
6. Date of Birth: / / 7. Daytime Phone #: ( ) - 8. Member Number:
9. Beneficiary Designation: I hereby make the following beneficiary designation with respect to all the insurance on my life under the Group Accidental Death and Dismemberment Insurance Plan that I select. If I am already covered under the plan, I hereby revoke any prior beneficiary designation. For multiple beneficiaries, contact the Administrator.

Beneficiary Name:

Social Security Number: - - Relation to Member:

2. Insurance Requested

YES, please enroll me in the selected California State Retirees Accidental Death & Dismemberment Insurance Plan.

Choose your level, fill in one circle:

$200,000.00 Cash Benefit:	○ Member Only: $20.00	○ Family* Plan: $25.00
$100,000.00 Cash Benefit:	○ Member Only: $10.00	○ Family* Plan: $12.50
$50,000.00 Cash Benefit:	○ Member Only: $5.00	○ Family* Plan: $6.25

If Family Plan selected above, please complete the following:

Spouse Name: Date of Birth: / /

Child Name: Date of Birth: / /

*Family refers to “eligible dependents”.

3. Authorization and Signature

I hereby enroll for coverage offered through the California State Employees Association (CSEA) Insurance Plan provided by New York Life Insurance Company, available to California State Retirees members. I authorize the Public Employees Retirement System (PERS) to deduct the monthly premium for such Group Insurance from my retirement allowance and to pay said premium in accordance with the law. I am a California State Retirees member in good standing. I understand that coverage will be effective on the first of the month following PERS deduction and receipt of my Application and PERS Deduction Authorization form by New York Life Insurance Company.

X Member Signature

X / / Date (MM/DD/YYYY)

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Retain a photocopy of this application for your records and return the original to:
CSEA ENDORSED INSURANCE PROGRAM CUSTOMER SERVICE
P.O. BOX 9997, PHOENIX, AZ 85068-9997

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ed: 6/17
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