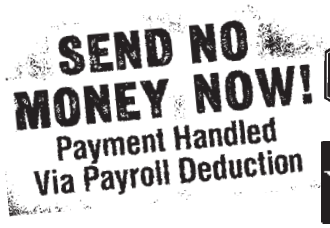
CSEA GROUP TRAVEL ACCIDENT INSURANCE PLAN ENROLLMENT FORM

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



California State Employees Association
Group Travel Accident 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: Affiliation: ◯ SEIU 60238 ◯ CSUEU 62741 ◯ ACSS 62740 ◯ Retirees 62742
9. Beneficiary Designation: I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Travel Accident 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 Travel Accident Insurance Plan. Choose your coverage - select one option:**

◯ **YES!** Enroll JUST ME for CSEA Group Travel Accident Insurance protection.

or

◯ **YES!** Enroll ALL OF US, including me and my eligible dependents, for CSEA Group Travel Accident Insurance Protection. (See Certificate for coverage amounts.)

My monthly payment will be deducted via payroll/PERS deduction for: Just Me: $5.50 or All of Us: $9.40

If enrolling ALL OF US, please complete the following:

Spouse Name: Date of Birth: / /

Child Name: Date of Birth: / /

Child Name: Date of Birth: / /

3. Authorization and Signature

I hereby enroll for Group Travel Accident coverage offered through the California State Employees Association (CSEA) Endorsed Insurance Program provided by New York Life Insurance Company. I authorize the State of California to deduct the monthly premium for such Group Insurance from my paycheck or pay warrant to pay said premium in accordance with the law. I am a CSEA Member in good standing. I understand that coverage will be effective on the first of the month following payroll deduction and receipt of my Application by New York Life Insurance Company.

X Member Signature

X / / Date (MM/DD/YYYY)

Licensed agent of record number 0155705

G-29148-0

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