

# 6-MONTH GROUP SHORT TERM DISABILITY INCOME INSURANCE PLAN APPLICATION

## HOW TO APPLY:

- Fill out application completely
- Include 2 copies of current pay stubs
- Sign & date
- Mail to: CSEA Member Benefits,  
1108 O Street, Suite 303  
Sacramento, CA 95814

**SEND NO MONEY NOW!**



California State Employees Association  
6-Month Short Term Disability Income 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 on the last page.

## 1. Member Information

1. Member Name: \_\_\_\_\_

2. Street Address: \_\_\_\_\_

3. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

4. Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Daytime Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

6. Sex:  Male  Female 7. Height \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ pounds

8. Do you intend to reside outside the U.S. or Canada in the next 12 months?  Yes  No If yes, what country? \_\_\_\_\_

9. Member Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## 2. Membership Affiliation-Occupational Status

Association Membership is required for participation in this plan.

1. Member Number: \_\_\_\_\_ 2. Member Affiliate: \_\_\_\_\_

3. Current Occupation / Profession: \_\_\_\_\_

4. Please describe your duties: \_\_\_\_\_

5. Gross Monthly Earning(s): \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_

6. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at FULL-TIME WORK?  Yes  No

7. Beneficiary Designation: I hereby make the following beneficiary designation with respect to all the insurance on my life under the 6-Month Group Short Term Disability Income 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: \_\_\_\_\_

## 3. Insurance Requested/Insurance Status

1. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability, including this plan?  Yes  No If yes, complete the following:

Company: \_\_\_\_\_ Plan: \_\_\_\_\_ Monthly Benefit: \$ \_\_\_\_ , \_\_\_\_ . \_\_\_\_ Benefit Period: \_\_\_\_ months/years

**YES**, I request coverage in the: 6-Month Group Short Term Disability Income Plan.

**To expedite your application, please include two recent payroll stubs for income verification.**

(Your monthly benefit and premiums are determined by your monthly earnings and age.)

I have included my two recent payroll stubs for income verification.

G-29115-1

**NEXT PAGE PLEASE →**

### 4. Statement of Health

*To the best of your knowledge and belief, answer the following questions as they apply to you. Notice to California Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.*

- A. Are you now ill or taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment?  Yes  No
- B. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:
  - 1) heart or circulatory trouble; elevated blood pressure; chest pain or pressure; gynecological or genitourinary disorders; disorder of breast or reproductive organs or functions; ulcers or digestive disorders; cancer; tumor or cyst; diabetes; mental or nervous disorder; emotional conditions; psychiatric care or psychotherapeutic treatment; fainting spells; convulsions or epilepsy; respiratory disorder; kidney or liver disorder (including hepatitis); enlarged lymph nodes or immunodeficiency disorder; thyroid disorder; blood disorder; albumin, blood, pus or sugar in urine; back trouble/disorder; arthritis; bone or joint disorder; varicose veins; hemorrhoids or hernia; disorder of eyes, ears, nose or sinuses; unexplained weight loss or accidental injury?  Yes  No
  - 2) other health or physical impairment including:
    - a) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
    - b) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?  Yes  No
    - c) Any other impairment?  Yes  No
- C. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?  Yes  No
- D. Are you now pregnant?  Yes  No
- E. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?  Yes  No
- F. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing or any type of organized motorized racing?  Yes  No
- G. Your Driver's License No.:                 State issued:
- H. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?  Yes  No
- I. **Except for Residents of Minnesota and Connecticut**, has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending?  Yes  No
- J. **For residents of Minnesota and Connecticut only**, has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?  Yes  No
- K. If you have answered "yes" to any of the previous questions, give complete details in the box below. (Attach a separate sheet if necessary.)

**Answers to Health Questions:**

Illness or Condition - Date of Onset - Duration - Treatment - Operation - Degree of Recovery and Date	Name and address of Physicians or other Practitioners and Hospitals where confined or treated

**NEXT PAGE PLEASE →**

## 5. Payment Options

Monthly payments will be deducted from my bank account through automatic payment (ACH).

Bank Name:

Bank Routing Number:

Bank Account Number:

Please provide a voided check for processing.

## 6. Authorization and Signature

I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

**AUTHORIZATION:** I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

### Fraud Notice

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 may be a crime and may subject such person to criminal and civil penalties.

**I authorize the Administrator to initiate debit entries for my regular payment. I understand my payment will be processed on or after the premium due date and will continue to be deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends.**

**By signing and dating this application, I request the insurance indicated; and I consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and attest to having read the IMPORTANT NOTICE enclosed and Fraud Notice indicated above, including how information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.**

**I am a CSEA Association Partnership Program Member in good standing and I am a permanent employee currently working at least 20 hours per week. I understand that coverage will be effective on the first of the month following payment and receipt of my Application by New York Life Insurance Company. I have read the Fraud Notice.**

**X**  **X**  /  /   
Member Signature Date (MM/DD/YYYY)

T25761

**Retain a photocopy of this application for your records and return the original to:  
MEMBER BENEFITS, 1108 O STREET, SUITE 303, SACRAMENTO, CA 95814**

## **CSEA Endorsed Insurance Program: 6 Month Short Term Disability**

### Overview:

#### **CSEA Endorsed Group Short Term Disability Plan Helps Replace Your Paycheck ... if you're off work**

- **Benefits Paid for Up To Six Months**  
If you become disabled as a result of a covered accidental injury, sickness or pregnancy, benefits will be paid directly to you – up to six months.
- **Benefits Fill Your Pay Gap**  
The CSEA Endorsed Group Short Term Disability benefits cover up to 75% of your basic monthly pay (combined with all your other sources of income and benefits\*).
- **Benefits Start Day One For Accidents**  
The CSEA Endorsed Group Short Term Disability starts paying benefits on the first day for a covered accident, 31st day for a covered sickness or pregnancy, or at the end of your sick leave, whichever is later.
- **Apply for coverage if you work at least 20 hours a week and are under age 70**
- **Budget-conscious**
- **30-Day Free Look**
- **Premiums waived while you're disabled**

\*Includes this disability plan, Workers' Compensation, Social Security, CAL PERS, disability retirement, "4800" time benefit plans, UCD or any state disability income plan, any nonindustrial disability insurance benefits or 50% of income from any Rehabilitative Employment.

If you have any questions regarding any of these benefits, please call 1-800-952-5283 or 916-326-4283.

### Benefits:

**Protect Your Paycheck with CSEA Association Partnership Program benefits** Do you depend on your income to pay day-to-day bills? The CSEA Endorsed benefits help replace more of your paycheck if you can't work. With CSEA Association Partnership Program coverage, you collect up to 75% of your basic monthly pay\* (combined with the sum of all your other sources of income and benefits).

\*Includes this disability plan, Workers' Compensation, Social Security, CAL PERS, disability retirement, "4800" time benefit plans, UCD or any state disability income plan, any non-industrial disability insurance benefits or 50% of income from any Rehabilitative Employment.

**Collect Benefits Starting the First Day for Accidents** The CSEA Endorsed Group Short Term Disability starts paying benefits on the first day for a covered accident, 31st day for a covered sickness or pregnancy, or at the end of your sick leave, whichever is later. And benefits continue as long as you're disabled – up to six months.

**Collect up to an EXTRA \$5,000 Benefit for Accidents** The CSEA Endorsed Short Term Disability Plan pays up to \$5,000.00 – on top of any other disability benefit – for certain physical injuries caused by a covered accident. Injuries must occur within 90 days after the date of the accident. The Certificate of Insurance includes specific details.

**Owe Nothing While Collecting Benefits** As long as you're paid CSEA Association Partnership Program disability benefits, the plan waives your premium – making it easier for you to get back on your feet.

**Get Peace of Mind – 2 Added Payments for Loved Ones** The CSEA Association Partnership Program Plan pays your family two extra monthly payments if you die while receiving benefits for a covered disability that lasted 30 days or longer. It's our way of making sure your loved ones are taken care of no matter what happens.

**Work Just 20 Hours a Week** You're eligible for coverage if you work for CSEA or any allied organization within the CSEA Association Partnership Program, are under age 70 and actively employed on a full-time basis (for at least 20 consecutive days and working at least 20 hours per week) with the State of California or any allied organization. You must reside in the state of California and not be on active duty with the military.

### You're Under No Obligation

If you decide your CSEA Endorsed Group Short Term Disability Protection isn't for you, just let us know in the first 30 days. We'll promptly refund your premiums ... no questions. No obligation.

### Rates:

Check Out These Premiums – Easy to Budget! Premiums for this plan are deducted through ACH. As a member of the CSEA Association Partnership Program, you qualify for discounted group rates for the 6 Month Group Short Term Disability Plan.

### Current 2011 Monthly Premiums\* for the 6 Month CSEA Short Term Group Disability Plan.

Monthly Income**	Monthly Benefit	Your monthly premium will be determined by your age:						
		Under 40	40-44	45-49	50-54	55-59	60-64	65-69
\$2,000-\$2,199	\$1,100	\$33.44	\$38.83	\$44.88	\$49.06	\$63.14	\$83.16	\$103.95
\$2,200-\$2,349	\$1,200	\$36.48	\$42.36	\$48.96	\$53.52	\$68.88	\$90.72	\$113.40
\$2,350-\$2,499	\$1,300	\$39.52	\$45.89	\$53.04	\$57.98	\$74.62	\$98.28	\$122.85
\$2,500-\$2,699	\$1,400	\$42.56	\$49.42	\$57.12	\$62.44	\$80.36	\$105.84	\$132.30
\$2,700-\$2,799	\$1,500	\$45.60	\$52.95	\$61.20	\$66.90	\$86.10	\$113.40	\$141.75
\$2,800-\$2,999	\$1,600	\$48.64	\$56.48	\$65.28	\$71.36	\$91.84	\$120.96	\$151.20
\$3,000-\$3,199	\$1,700	\$51.68	\$60.01	\$69.36	\$75.82	\$97.58	\$128.52	\$160.65
\$3,200-\$3,399	\$1,800	\$54.72	\$63.54	\$73.44	\$80.28	\$103.32	\$136.08	\$170.10
\$3,400-\$3,599	\$1,900	\$57.76	\$67.07	\$77.52	\$84.74	\$109.06	\$143.64	\$179.55
\$3,600-\$3,799	\$2,000	\$60.80	\$70.60	\$81.60	\$89.20	\$114.80	\$151.20	\$189.00
\$3,800-\$3,999	\$2,100	\$63.84	\$74.13	\$85.68	\$93.66	\$120.54	\$158.76	\$198.45
\$4,000-\$4,199	\$2,200	\$66.88	\$77.66	\$89.76	\$98.12	\$126.28	\$166.32	\$207.90
\$4,200-\$4,399	\$2,300	\$69.92	\$81.19	\$93.84	\$102.58	\$132.02	\$173.88	\$217.35
\$4,400-\$4,599	\$2,400	\$72.96	\$84.72	\$97.92	\$107.04	\$137.76	\$181.44	\$226.80
\$4,600-\$4,799	\$2,500	\$76.00	\$88.25	\$102.00	\$111.50	\$143.50	\$189.00	\$236.25
\$4,800-\$4,899	\$2,600	\$79.04	\$91.78	\$106.08	\$115.96	\$149.24	\$196.56	\$245.70
\$4,900-\$5,099	\$2,700	\$82.08	\$95.31	\$110.16	\$120.42	\$154.98	\$204.12	\$255.15
\$5,100-\$5,299	\$2,800	\$85.12	\$98.84	\$114.24	\$124.88	\$160.72	\$211.68	\$264.60
\$5,300-\$5,499	\$2,900	\$88.16	\$102.37	\$118.32	\$129.34	\$166.46	\$219.24	\$274.05
\$5,500-\$5,699	\$3,000	\$91.20	\$105.90	\$122.40	\$133.80	\$172.20	\$226.80	\$283.50
\$5,700-\$5,899	\$3,100	\$94.24	\$109.43	\$126.48	\$138.26	\$177.94	\$234.36	\$292.95
\$5,900-\$6,099	\$3,200	\$97.28	\$112.96	\$130.56	\$142.72	\$183.68	\$241.92	\$302.40
\$6,100-\$6,299	\$3,300	\$100.32	\$116.49	\$134.64	\$147.18	\$189.42	\$249.48	\$311.85
\$6,300-\$6,499	\$3,400	\$103.36	\$120.02	\$138.72	\$151.64	\$195.16	\$257.04	\$321.30

Benefits for which you are eligible are based on your monthly earnings.

\*There is a \$1.50 per month administrative service fee in addition to the above premiums.

\*\* If your income is not listed on the chart above, please call one of our benefit representatives at 1-800-952-5283 for a personal rate quote.

New York Life reserves the right to change rates on a class-wide basis. Benefit amounts are not guaranteed and are subject to change by the Policyholder and New York Life. The premiums shown reflect the current rates (as of December 1, 2005) and benefit structure. Premiums are subject to change by agreement between New York Life Insurance Company and CSEA, but not more than twice in any twelve-month period. Your rates may change only if they are changed for others in the same class or insured under this group policy. For example, a class of insured is a group of people with the same age and gender. Premium for this plan is deducted via ACH. Future benefits are subject to change by agreement between New York Life Insurance Company and CSEA.

**To expedite your application, please include two recent payroll stubs for income verification.**

### FAQs:

#### **Am I at risk of becoming disabled?**

A. You face a 1 in 3 chance between (ages 35-65) of being disabled for more than 90 days<sup>1</sup>. And according to experts, disabilities can help you avoid depleting your savings and retirement accounts<sup>2</sup>.

<sup>1</sup> Consumer Reports Money Advisor, August 2010

<sup>2</sup><http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/ltdbrochure.pdf>

#### **How does the CSEA Endorsed Group Short Term Disability insurance plan replace my salary?**

A. Disability insurance by design replaces part of your monthly income. The CSEA Endorsed Group Short Term Disability benefits cover up to 75% of your basic monthly salary and starts as soon as your first day of disability if due to an accident, or 31st day if disabled due to illness or pregnancy.

#### **What is the difference between short term benefits and long term disability insurance?**

A. Short term disability coverage can start as early as the first day of a covered accident or after 31 days when unable to work due to an illness, injury or the birth of a child. In California, employers are obligated to offer 52 weeks of short term coverage. Long term disability insurance generally takes over after short term disability benefits end and last for extended periods of time, such as five years. No states require employers to offer long term disability coverage.

Sources:

<http://www.smartmoney.com/plan/insurance/how-to-buy-disability-insurance-1304922417981/>

<http://www.consumerfed.org/elements/www.consumerfed.org/file/finance/ltdbrochure.pdf>

#### **Do I qualify for coverage if I work less than 40 hours a week?**

A. Yes. Apply for benefits as long as you work 20 hours a week for at least 20 consecutive service days with the State of California or any allied organization.

#### **Can I keep CSEA Endorsed Short Term Disability Coverage if I change my job?**

A. Yes. Unlike employer provided disability protection, you can "take" your CSEA Association Partnership Program coverage with you if you switch jobs as long as you remain an eligible CSEA Association Partnership Program member and are actively employed with the state of California or any allied organization.

#### **Will my family be taken care of?**

A. First, you don't pay premiums while you're disabled and collecting CSEA Association

Partnership Program disability benefits. Plus, the CSEA Endorsed Short Term Disability Plan adds two extra monthly payments if you die while receiving benefits for a covered disability that lasted 30 days or longer.

#### **What if my disability is due to an accident?**

A. Accidents are one of the leading reasons for disabilities. That's why the CSEA Endorsed Short Term Disability Plan pays up to \$5,000.00 – on top of any other disability benefit – for certain physical injuries caused by a covered accident. The Certificate of Insurance includes specific details.

#### **How do I pay my premiums?**

A. For easy budgeting, premiums are deducted from your bank via ACH. Rates are more affordable than if you purchased coverage on your own because of the combined buying power of the CSEA Association Partnership Program.

#### **What if I change my mind after I apply?**

A. After you're approved for coverage, you'll receive a Certificate of Insurance. Take up to 30 days to decide if this protection is right for you. If you change your mind, your premiums will be promptly refunded.

#### Terms:

Your CSEA Group Short Term Disability benefits can begin following approval from New York Life. Your coverage will take effect on the first day of the month after your first payment has been received. Once approved, you will receive a Certificate of Insurance describing the terms and conditions of your coverage. If you are not working full-time on the date your insurance is scheduled to become effective, your insurance will not become effective until you return to full-time work. However, if you are not actively working due to a non-working day, you will still become insured on the scheduled effective date provided you would have been able to do your regular job on that non-working day. If you become disabled as a result of a covered accidental injury, sickness or pregnancy, benefits will be paid during the continuance of your disability. Benefits begin with the first day of a covered accident, 31st day for a sickness or pregnancy, or at the end of your sick leave, whichever is later.

Premiums are subject to change by agreement between New York Life Insurance Company and CSEA, but not more than twice in any twelve-month period. Your rates may change only if they are changed for others in the same class of insured under this group policy. For example, a class of insured is a group of people with the same age and gender. Premium for this plan is deducted through ACH. Future benefits are subject to change by agreement between New York Life and CSEA.

#### **IMPORTANT INFORMATION**

**Definition of "disability"** — or "disabled" means that during a period of disability (including the qualifying period), an injury, sickness or pregnancy requires you to be under the regular care and attendance of a doctor, and prevents you from performing your usual occupation. If you voluntarily decide to work at any occupation, you would no longer be considered disabled.

**Definition of "basic monthly earnings"** — The monthly rate of pay from the employer. Overtime pay, commissions, bonuses and other pay (not considered as basic wages or salary) are not included.

**Successive periods of disability** — Due to the same or related cause will be considered as one period of disability unless separated by a 3-month period during which you return to full-time work with the employer. Successive periods of disability due to an unrelated cause will be considered a new disability when separated by at least one completed day of active work.

**Pre-existing conditions** — Benefits will not be paid for disabilities due to non-disclosed pre-existing conditions, as defined below until the end of the earlier of (1) 12 consecutive months after the effective date of coverage during which the covered person has had no treatment or medical advice for that condition or (2) 24 consecutive months during which the person has been insured under the policy. "Pre-Existing Condition" means any injury, sickness, mental, emotional or nervous disorder or related illness for which a person consulted a doctor, received any medical services or supplies or took any medication during the 12 months immediately before becoming covered under this plan and which was not disclosed on the person's request for coverage. A condition which was fully disclosed on the application for insurance is not considered a Pre-Existing Condition.

**Rehabilitative employment** — If you are disabled from your regular job but accept rehabilitative employment within 31 days after a period of disability for which a monthly benefit is payable, 50% of any salary, wages, partnership or proprietorship draw, commissions, or similar pay received from rehabilitative employment will be considered along with your other sources of income and benefits when determining the monthly benefit payable.

**What is not covered under this plan (Exclusions and Limitations)** — This plan does not pay benefits for a disability and/or confinement that began before a person becomes an insured member; a disability, confinement and/or injury that: occurs during or is due or related to incarceration or participation in the commission of a felony, an illegal occupation or activity, an insurrection, terrorist activity or a riot; any disability, confinement or injury caused by war or any act of war or an armed conflict which involves the armed forces of one or more countries, whether declared or not; intentionally self-inflicted injury, while sane or insane; A disability, confinement or injury that occurs or is due or related to duty in the military, naval or air service of any country; a disability that is due to a pre-existing condition and specifically excluded from coverage; a disability that no longer requires the regular care and attendance of a doctor or any period of disability for which insured member is not under regular care and attendance of a doctor; an injury that is due or related to or occurs during the course of any occupation for pay or profit; or a sickness that entitles the insured member to benefits under a Worker's Compensation Act or similar Act. (The above exclusions and limitations apply to the Disability Insurance Plan, for Accidental Death and Dismemberment exclusions and limitations; please refer to the Certificate of Insurance for details.)

**Coverage may continue until** — (1) the insured member retires or ceases active full-time work of at least 20 hours per week (other than for reason of disability); (2) membership in the California State Employees Association ends; (3) active duty in the armed forces (except for training purposes of 2 months or less) begins; (4) premium contributions are not paid when due; (5) the Group Policy is terminated by the policyholder or New York Life; (6) the member is no longer a permanent resident of the United States, District of Columbia, Puerto Rico or Canada.

**(Please read and retain for your records)**  
**IMPORTANT NOTICE:**

**How New York Life Obtains Information and Underwrites Your Request for Group Disability Income Insurance**

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (formerly known as Medical Information Bureau). MIB and other insurance companies may also furnish New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other application for insurance). The information provided may include information

that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying the Administrator in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may be come subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

New York Life may release this information to the plan administrator, MIB, other insurance companies to whom you may apply for insurance, or to whom a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may make a brief report to MIB; however, we will not disclose our underwriting decision. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or non-medical information may be given to the Bureau, which may then be furnished to member companies.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901 (TTY 866-346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

***For NM Residents: PROTECTED PERSONS<sup>1</sup> have a right of access to certain CONFIDENTIAL ABUSE INFORMATION<sup>2</sup> we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.***

***<sup>1</sup>PROTECTED PERSON means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.***

***<sup>2</sup>CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate or a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.***

Endorsed by:



The CSEA incurs certain administrative expenses in connection with this sponsored program. To provide and maintain this valuable membership benefit it is reimbursed for such expenses.

**California State Employees Association**

Administered by A.G.I.A., Inc.  
PO Box 9997  
Phoenix, AZ 85068-0997

Questions? Call toll-free 1-800-952-5283.

A.G.I.A., Inc. is licensed and authorized to transact business in all 50 United States, and the District of Columbia. Their state of domicile is California. John Wigle, California Agent license number: 0482924. John Wigle Arkansas Agent license number: 46424.

Underwritten by:  
New York Life Insurance Company  
51 Madison Avenue  
New York, NY 10010

Under Group Policy G-29115-1 on Policy Form GMR-FACE/G-29115.  
New York Life is licensed/authorized to transact business in all 50 United States, District of Columbia, Puerto Rico and Canada. However, not all plans it underwrites are available in all states. Please check the group plan details sections for current availability.

New York Life Insurance Company's state of domicile is New York and their NAIC ID # is 55915.

This brochure is not a policy or Certificate of Insurance. It merely summarizes the principal features and is for informational purposes only. The complete terms and provisions of coverage and the conditions under which it may be kept in force are contained in the group Master Policy issued to the association.

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