GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE APPLICATION

FOR MEMBERS OF THE
CALIFORNIA SCHOOL EMPLOYEES ASSOCIATION

To Apply:
Complete This Form and Return To:
ADMINISTRATOR
CSEA
GROUP INSURANCE PROGRAM
P.O. Box 10374 • Des Moines, IA
50306-8812

QUESTIONS?
Call: 1-877-492-3862
E-mail: customerservice.service@mercer.com

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

(Please make any necessary corrections to your full name and street address if shown below.)

Name _____

Address _____

City _____

State, ZIP _____

Social Security #: ☐☐☐-☐☐-☐☐☐☐

Home Phone: (_____)_____

Work Phone: (_____)_____

Fax: (_____)_____

Email Address: _____
Mercer Consumer will not share your email information

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow(ed)

☐ Civil Union* ☐ Domestic Partner* (submit a completed Declaration of Domestic Partnership form.)
*Eligibility for Domestic Partner/Civil Union is determined by state law.

Are you presently insured under any CSEA Group Life Insurance Plans? ☐ Yes ☐ No

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?

Member: ☐Yes, Country_____ For how long? _____ ☐No

Spouse: ☐ Yes, Country_____ For how long? _____ ☐ No

	DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member: _____	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
Spouse: _____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
Child(ren)*: _____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F

* See Plan Information/Plan Details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. Membership Affiliation:

Are you currently a member in good standing with the CSEA? ☐ Yes ☐ No Membership Number: _____

☐ Active 50961/50962/1018/52247 CSEA Member Since:_____

☐ Retired 50961/50963/1018/52247 Retirement Date:_____

3. Payment Option: (Choose only one)

☐ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the CSEA Group Insurance Program Administrator to make ☐ monthly ☐ quarterly ☐ semiannual ☐ annual withdrawals against the account specified on the attached voided check, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Term Life Insurance Plan. (Enclose a VOIDED check, as applicable.)

X _____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

☐ **OPTION 2: PERIODIC BILLING:** ☐ Annual ☐ Semiannual ☐ Quarterly

4. Insurance Requested: (Refer to the Plan Information/Plan Details for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

Active Members:

☐ **New Coverage** – Member Life with AD&D Insurance Amount: $_____

☐ **New Coverage** – Spouse Life Insurance Amount: $_____

☐ **New Coverage** – Child Life Insurance Amount: $_____

☐ **Increase** Member Life with AD&D Insurance Amount from $_____ to $_____

☐ **Increase** Spouse Life Insurance Amount from $_____ to $_____

☐ **Increase** Child Life Insurance Amount from $_____ to $_____

Note: Dependent coverage may not exceed Member coverage.

Retired Members:

☐ **New Coverage** – Member Life Insurance Amount: $_____

☐ **New Coverage** – Dependent Life Insurance for Eligible Spouse and/or Child(ren) _____

Do you have other life insurance in force?
If "Yes," total amount in all companies: Member $_____ Spouse $_____

Do you have other insurance applications pending?
If "Yes," indicate amount and company:
Member $_____ Company_____ Spouse $_____ Company_____

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.

	Member		Spouse	
	Yes	No	Yes	No
RESIDENTS OF NEW YORK: I have read the important Replacement Information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?	☐	☐	☐	☐
RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy?	☐	☐	☐	☐

5. Beneficiary Designation: (Insert name, relationship and address)

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life and Accidental Death and Dismemberment Insurance Plan and, if I am already covered under the Plan, I revoke any prior designation. The beneficiary for dependent coverage shall be the insured member. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet, if necessary.)

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

6. Statement of Health: (Please initial and date any changes you make on this form.)

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	Member		Spouse	
	Yes	No	Yes	No
a. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐	☐	☐	☐
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	☐	☐	☐	☐
c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	☐	☐	☐	☐
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐	☐	☐
e. Is any person to be insured now pregnant?	☐	☐	☐	☐
f. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:				
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐	☐	☐
2. Arthritis, back trouble, bone or joint disorder?	☐	☐	☐	☐
3. Fainting spells, convulsions or epilepsy?	☐	☐	☐	☐
4. Sugar, blood, albumin or pus in urine?	☐	☐	☐	☐
5. Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐	☐	☐
6 Disorder of breast or reproductive organs or functions?	☐	☐	☐	☐
7. Nervous or mental disorder, emotional condition or psychiatric care?	☐	☐	☐	☐
8. Cancer, tumor or cyst?	☐	☐	☐	☐
9 Varicose veins, hemorrhoids or hernia?	☐	☐	☐	☐
10. Disorder of eyes, ears, nose or sinuses?	☐	☐	☐	☐
11. Thyroid, liver or respiratory disorder?	☐	☐	☐	☐
12. Alcoholism or drug habit?	☐	☐	☐	☐
13. Disorder of the blood?	☐	☐	☐	☐
14. Other health or physical impairment including:	☐	☐	☐	☐
(i). Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)	☐	☐	☐	☐
(ii). Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?	☐	☐	☐	☐
(iii). Any other impairment?	☐	☐	☐	☐

6. Statement of Health: (continued)

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" GIVE COMPLETE 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.")

Question Letter/No.	Name of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

7. Authorization

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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health 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 reinsurers, 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 for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. 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.

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 shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE indicated below and Fraud Notices indicated below, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature X _____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X_____ **Date** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) (PLEASE SIGN AND DATE IN INK)

Owner's Signature X _____ **Date** _____
(NECESSARY ONLY IF MEMBER PREVIOUSLY TRANSFERRED OWNERSHIP OF HIS/HER GROUP TERM LIFE INSURANCE)

FRAUD NOTICE – *For Residents of all states except those listed below and NEW YORK:* 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**. RESIDENTS OF CO,** the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR RESIDENTS OF D.C., WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

RESIDENTS OF KS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Term Life Insurance Plan and Accidental Death & Dismemberment Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify 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. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life 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 become 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.

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.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. 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.

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. Information for consumers about MIB may be obtained on its Web site at www.mib.com.

For NM Residents: *PROTECTED PERSONS[1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION[2] 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.*

[1]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 or prospective insured person.

[2]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 family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8/12 ed.**

Group Term Life Insurance with Accidental Death & Dismemberment Insurance Plan

Underwritten by New York Life Insurance Company

For California School Employees Members and Their Families

HELP SECURE YOUR FAMILY'S FUTURE

An adequate life insurance plan is added protection against the uncertainty of tomorrow. In the unfortunate event of your death, or that of your spouse, family members who are left may be forced to change educational plans, living arrangements, or lifestyle. With the loss of your earning power, what would happen to your loved ones?

Most CSEA members already have some life insurance protection. But statistics show they probably don't have enough protection. Many financial planners suggest you carry 5 to 9 times your annual salary in life insurance. Of course, life insurance needs vary according to your family and financial situation (living expenses, mortgage payments, college education for children). For example: in an average situation, a 34-year old with a family and a home, making $40,000 per year might consider a minimum of $200,000 of life insurance…and similarly, a 49-year old making $55,000 per year might consider carrying at least $275,000 of coverage.

WHO IS ELIGIBLE

Active CSEA Members are eligible to apply for coverage for themselves, their lawful spouses/domestic partners and unmarried dependent children up to age 26. In order to become insured, satisfactory evidence of insurability must be provided and the required premium contribution must be paid. To be considered "Active", a Member must be **ACTIVELY-AT-WORK**: actively performing, for pay or profit, the regular duties of one's normal occupation on a basis of receiving paychecks in at least ten months during the year, from September to June, at a place where such duties are normally performed or other location to which travel is required.

Retired CSEA Members are eligible for coverage if they maintain Retired Membership in CSEA and were insured for the Group Term Life Insurance as an Active Member prior to their retirement. Retirees must apply for coverage within 120 days of their retirement date and coverage may not exceed the amount that they had as an active member. If a Retiree does not apply within 120 days of their retirement date, they may not continue their Group Term Life Insurance.

A dependent who is a member is eligible for either member or dependent coverage, but not both. If both member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

This coverage is available only for residents of the United States (excluding and territories) and Puerto Rico.

WHAT YOU CAN CHOOSE

MEMBER COVERAGE OPTIONS

Active Members: Options of $25,000 to $300,000 (in multiples of $25,000)
Retired Members: Option A–$13,500, Option B–$27,000, Option C–$40,500
(Retiree coverage may not exceed the plan you had as an active member.)

SPOUSE/DOMESTIC PARTNER COVERAGE OPTIONS

Active Members: Options of $2,000 to $26,000 (in multiples of $2,000, may not exceed 100% of member coverage)
Retired Members: Amount is based on the Retired Member's Age

Less than age 67–$3,000
Age 67-69–$600
Age 70 and Over–$300

DEPENDENT CHILD COVERAGE OPTIONS

Active Members: $2,000 to $10,000 (in multiples of $2,000)
Retired Members: $1,000

Amounts of Insurance at Later Ages

The amount of Life Insurance for Active Members, Retired Members, and Spouses of Active Members will reduce to 65% when the member reaches age 65; to 50% at age 70; to 35% at age 75; and to 20% at age 80. Please refer to the enclosed premium rate charts for additional information regarding these coverage reductions and the amount of coverage that you may elect as a new enrollee over age 64. The total amount of coverage an individual may have under all group life insurance plans underwritten by New York Life Insurance Company may not exceed $2,000,000.

Exclusions

Life insurance benefits are payable for death resulting from any cause, anywhere in the world, except suicide, whether sane or insane, during the first two years of coverage – in which case, benefits will be reduced to a refund of premiums paid.

DOUBLE YOUR COVERAGE WITH GROUP AD&D

Active Members* insured under the Group Term Life insurance automatically receive Group Accidental Death and Dismemberment (AD&D) insurance equal to their life insurance amount. If your loss is due to a covered accidental death, the plan can pay your life benefit amount plus your AD&D benefit, which doubles your life benefit amount. It also pays a percentage of your amount if you are seriously injured and suffer significant losses described below.

Covered Loss	Percentage of Principal Sum
Loss of life	100%
Loss of two limbs	100%
Loss of sight of both eyes	100%
Loss of one limb and sight of one eye	100%
Loss of speech and hearing	100%
Loss of movement of both upper and lower limbs	100%
Loss of movement of both lower limbs	75%
Loss of movement of both upper and lower limbs on one side of the body	50%
Loss of one limb	50%
Loss of sight of one eye	50%
Loss of speech or hearing	50%
Loss of thumb and index finger on one hand	25%

The injury must be directly and independently caused by an accident while coverage is in force, and must result in a Covered Loss within 365 days.

Only one principal sum (the largest applicable) is payable for a loss to the same limb due to or related to any one accident. Loss of sight, speech or hearing means total and permanent loss. Loss of limb means severance through or above the wrist or ankle joint. Loss of movement means total and permanent paralysis of such limb.

*This Group Accidental Death and Dismemberment insurance benefit is not available for spouses, dependent children, or Retired Members.

Exclusions and Limitations – AD&D

No benefit will be payable for: any loss that occurs during or is due or related to military service, your incarceration or participation in (except as a victim) an illegal occupation/activity or the commission of a crime, your voluntary intake of drugs, narcotics or alcohol (unless prescribed by a physician), any declared or undeclared war or act thereof, or operation, riding in or descending from any aircraft except when riding as a passenger; or for any loss that is due or related to: a physical or mental sickness or medical/surgical treatment thereof, or suicide or intentionally self-inflicted injury while sane or insane.

PLAN FEATURES

VALUABLE BENEFIT... with no increase in premium contributions

The Living Benefit or "accelerated death benefit" is designed to provide members with the option to have a portion of a terminally ill insured's life insurance benefit paid while he/she is still alive.

The money received under this feature can be used however you see fit. For example, it can help pay medical bills and other outstanding debts and financial obligations…it can help you keep your savings and assets intact…it can help you maintain your quality of living.

To qualify for this benefit, a person must be insured under this Plan and diagnosed as having a life expectancy of 12 months or less. Proof of terminal illness will consist of a statement from a doctor and any other medical information New York Life Insurance Company believes necessary to confirm the person's status.

You can request payment equal to 75% of a qualified terminally ill person's inforce coverage. The request must be made at least 12 months prior to that person's scheduled coverage termination age, and the amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.) If a scheduled reduction will occur within one year of the date the advance payment will be made, the benefit payable will be 75% of the reduced coverage. Note: An insured will be eligible for only one terminal illness benefit during his/her lifetime.

Please note that the receipt of this benefit may affect your eligibility for public assistance programs and may be taxable.

You may wish to consult the appropriate social services agency and a qualified tax advisor about how this may affect your personal situation.

Premiums Are Waived If You're Totally Disabled

If you become totally disabled before age 60, and remain so disabled for six months or longer, your insurance will be continued as long as you remain totally disabled – for both you and your insured family members – without additional premium contributions. The amount continued will be based on the options under which you and your dependents were insured at the time your disability began. The Waiver of Premium benefit will continue until the insured member is no longer totally disabled or reaches age 65, whichever comes first. You may be asked to provide evidence of your continued total disability from time to time.

Your Choice of Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally. The member is the beneficiary for spouse's and children's coverage. If you wish to designate a different beneficiary, please contact the Administrator for the proper form.

Incontestability

The validity of any amount of your life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and non-payment of premium contributions.

OTHER IMPORTANT INFORMATION

Ownership of Insurance

"Owner" means the person or entity with rights of ownership of this insurance as described in the Certificate of Insurance. If a transfer of ownership has been recorded by or on behalf of New York Life, or if initial ownership is by other than the member according to the information provided on the application, references throughout this Plan Information to "you" or "member" will mean "owner," as applicable.

Effective Date

Insurance will take effect on the date your application is approved by New York Life Insurance Company provided the initial contribution has been paid within 31 days after the date you are billed and any person to be insured is actively performing the normal activities of a person in good health of like age on the date of approval.

Any person who is not performing his/her normal daily activities as required will not become insured until the day he/she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible.

When Coverage Ends

Insurance for you can remain in force until: (a) premium contributions are not paid when due, (b) CSEA membership ends, (c) the group plan is terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong, and (d) you request to terminate insurance. In addition, dependent coverage will terminate when your coverage terminates, or when the eligibility requirements are no longer being met. Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance. Please note your AD&D coverage will end if you begin full-time active duty in the armed forces.

If you're an Active Member, your coverage will end when you are no longer **ACTIVELY-AT-WORK**, as defined. However, if your insurance ends due to your retirement, you may elect to continue your **life insurance** under one of the available options. (AD&D insurance and dependent coverage may not be continued after you retire.)

Group Conversion Privilege

The Plan provides conversion privileges under certain circumstances of involuntary termination as described in the Certificate of Insurance.

CERTIFICATE OF INSURANCE

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the California School Employees Association.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Plan.

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated, and you will be sent a full refund, no questions asked!

RENEWAL PAYMENTS AND CLAIMS

Once you are accepted into the Plan, you will have a 60 day grace period for your payment of renewal premium contribution. When you want to submit a claim, call or write the Administrator for claim forms.

HOW TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing with CSEA. Please wait until your application for membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact CSEA directly.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your application may be used as the basis for invalidating your insurance.

The Group Term Life Insurance Plan is medically underwritten based on the information provided by you on your Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the Plan.

Apply in Three Easy Steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application. Be sure to indicate whether you are requesting coverage for your spouse and children.
2. Make out your check for the total premium contribution due, payable to: Administrator, CSEA Group Insurance Program.

   If you choose the convenient Electronic Funds Transfer (EFT), be sure to include a voided check in addition to the check for the first payment due.

3. Mail the completed application with your check to:
   CSEA Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

If you have questions about your eligibility or the features of this Plan, call a Customer Service Representative toll-free at 1-877-492-3862.

This Group Term Life Insurance Plan Is Administered By:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
CSEA Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

Questions: 1-877-492-3862
Web: www.cseainsure.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

This Group Term Life Insurance Plan Is Underwritten By:

NEW YORK LIFE

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29354-0
on Policy Form GMR-FACE/G-29354-0

LIAD113P-50961

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Current 2019 Premium Rates

The initial cost of insurance for a member, spouse, and child(ren) is based on the member's attained age when insurance becomes effective and the amount of insurance selected. The cost increases as the member grows older.

Premium contributions will vary depending upon the options chosen.

Monthly Premiums for Active Members Under Age 65

Benefit Amount	Under Age 25	Age 25–29	Age 30–34	Age 35–39	Age 40–44	Age 45–49	Age 50–54	Age 55–59	Age 60–64
25,000	$1.75	$2.00	$2.50	$3.25	$4.25	$6.25	$9.75	$17.00	$24.50
50,000	$3.50	$4.00	$5.00	$6.50	$8.50	$12.50	$19.50	$34.00	$49.00
75,000	$5.25	$6.00	$7.50	$9.75	$12.75	$18.75	$29.25	$51.00	$73.50
100,000	$7.00	$8.00	$10.00	$13.00	$17.00	$25.00	$39.00	$68.00	$98.00
125,000	$8.75	$10.00	$12.50	$16.25	$21.25	$31.25	$48.75	$85.00	$122.50
150,000	$10.50	$12.00	$15.00	$19.50	$25.50	$37.50	$58.50	$102.00	$147.00
175,000	$12.25	$14.00	$17.50	$22.75	$29.75	$43.75	$68.25	$119.00	$171.50
200,000	$14.00	$16.00	$20.00	$26.00	$34.00	$50.00	$78.00	$136.00	$196.00
225,000	$15.75	$18.00	$22.50	$29.25	$38.25	$56.25	$87.75	$153.00	$220.50
250,000	$17.50	$20.00	$25.00	$32.50	$42.50	$62.50	$97.50	$170.00	$245.00
275,000	$19.25	$22.00	$27.50	$35.75	$46.75	$68.75	$107.25	$187.00	$269.50
300,000	$21.00	$24.00	$30.00	$39.00	$51.00	$75.00	$117.00	$204.00	$294.00

The above premiums reflect the monthly rate for the Term Life Insurance with the AD&D benefit.

Monthly Premiums for Active Members Age 65 and Above

Benefit Amount Under Age 65	Benefit Amount Age 65-69	Monthly Premium	Benefit Amount Age 70-74	Monthly Premium	Benefit Amount Age 75-79	Monthly Premium
25,000	16,250	$27.14	12,500	$41.50	8,750	$43.05
50,000	32,500	$54.28	25,000	$83.00	17,500	$86.10
75,000	48,750	$81.41	37,500	$124.50	26,250	$129.15
100,000	65,000	$108.55	50,000	$166.00	35,000	$172.20
125,000	81,250	$135.69	62,500	$207.50	43,750	$215.25
150,000	97,500	$162.83	75,000	$249.00	52,500	$258.30
175,000	113,750	$189.96	87,500	$290.50	61,250	$301.35
200,000	130,000	$217.10	100,000	$332.00	70,000	$344.40
225,000	146,250	$244.24	112,500	$373.50	78,750	$387.45
250,000	162,500	$271.38	125,000	$415.00	87,500	$430.50
275,000	178,750	$298.51	137,500	$456.50	96,250	$473.55
300,000	195,000	$325.65	150,000	$498.00	105,000	$516.60

The above premiums reflect the Active Member monthly rate for the Term Life Insurance with the AD&D benefit.
For 80+ rates please contact the plan administrator at 1-877-492-3862.

The amount of Life Insurance for Spouses of Active Members will reduce to 65% when the member reaches age 65; to 50% at age 70; to 35% at age 75; and to 20% at age 80. The above rate chart outlines these coverage reductions and the amount of insurance that you may elect as a new enrollee.

Current 2019 Premium Rates (Cont'd)

Monthly Premiums for Spouses of Active Members Under Age 65

Benefit Amount	Under Age 25	Age 25–29	Age 30–34	Age 35–39	Age 40–44	Age 45–49	Age 50–54	Age 55–59	Age 60–64
2,000	$0.10	$0.12	$0.16	$0.22	$0.30	$0.46	$0.74	$1.32	$1.92
4,000	$0.20	$0.24	$0.32	$0.44	$0.60	$0.92	$1.48	$2.64	$3.84
6,000	$0.30	$0.36	$0.48	$0.66	$0.90	$1.38	$2.22	$3.96	$5.76
8,000	$0.40	$0.48	$0.64	$0.88	$1.20	$1.84	$2.96	$5.28	$7.68
10,000	$0.50	$0.60	$0.80	$1.10	$1.50	$2.30	$3.70	$6.60	$9.60
12,000	$0.60	$0.72	$0.96	$1.32	$1.80	$2.76	$4.44	$7.92	$11.52
14,000	$0.70	$0.84	$1.12	$1.54	$2.10	$3.22	$5.18	$9.24	$13.44
16,000	$0.80	$0.96	$1.28	$1.76	$2.40	$3.68	$5.92	$10.56	$15.36
18,000	$0.90	$1.08	$1.44	$1.98	$2.70	$4.14	$6.66	$11.88	$17.28
20,000	$1.00	$1.20	$1.60	$2.20	$3.00	$4.60	$7.40	$13.20	$19.20
22,000	$1.10	$1.32	$1.76	$2.42	$3.30	$5.06	$8.14	$14.52	$21.12
24,000	$1.20	$1.44	$1.92	$2.64	$3.60	$5.52	$8.88	$15.84	$23.04
26,000	$1.30	$1.56	$2.08	$2.86	$3.90	$5.98	$9.62	$17.16	$24.96

Monthly Premiums for Spouses of Active Members Age 65 and Above

Benefit Amount Under Age 65	Benefit Amount Age 65–69	Monthly Premium	Benefit Amount Age 70–74	Monthly Premium	Benefit Amount Age 75-79	Monthly Premium
2,000	1,300	$2.15	1,000	$3.30	700	$3.43
4,000	2,600	$4.29	2,000	$6.60	1,400	$6.86
6,000	3,900	$6.44	3,000	$9.90	2,100	$10.29
8,000	5,200	$8.58	4,000	$13.20	2,800	$13.72
10,000	6,500	$10.73	5,000	$16.50	3,500	$17.15
12,000	7,800	$12.87	6,000	$19.80	4,200	$20.58
14,000	9,100	$15.02	7,000	$23.10	4,900	$24.01
16,000	10,400	$17.16	8,000	$26.40	5,600	$27.44
18,000	11,700	$19.31	9,000	$29.70	6,300	$30.87
20,000	13,000	$21.45	10,000	$33.00	7,000	$34.30
22,000	14,300	$23.60	11,000	$36.30	7,700	$37.73
24,000	15,600	$25.74	12,000	$39.60	8,400	$41.16
26,000	16,900	$27.89	13,000	$42.90	9,100	$44.59

For 80+ rates please contact the plan administrator at 1-877-492-3862.

The amount of Life Insurance for Spouses of Active Members will reduce to 65% when the member reaches age 65; to 50% at age 70; to 35% at age 75; and to 20% at age 80. The above rate chart outlines these coverage reductions and the amount of insurance that you may elect as a new enrollee.

Current 2019 Premium Rates (Cont'd)

Children of Active Members

Benefit Amount	Monthly Premiums
$2,000	$0.20
$4,000	$0.40
$6,000	$0.60
$8,000	$0.80
$10,000	$1.00

The above premium covers all eligible children, regardless of how many are insured.

Semi-Annual Premiums for Retired Members Under Age 65

Retired Member's Age	Option A $13,500	Option B $27,000	Option C $40,500
Under 25	$8.51	$17.01	$25.52
25-29	$8.51	$17.01	$25.52
30-34	$8.51	$17.01	$25.52
35-39	$13.91	$27.81	$41.72
40-44	$20.93	$41.85	$62.78
45-49	$32.27	$64.53	$96.80
50-54	$44.96	$89.91	$134.87
55-59	$59.94	$119.88	$179.82
60-64	$105.98	$211.95	$317.93

Semi-Annual Premiums for Retired Members Age 65 and Above

Benefit Amount Under Age 65	Benefit Amount Age 65–69	Semi-Annual Premium	Benefit Amount Age 70–74	Semi-Annual Premium	Benefit Amount Age 75–79	Semi-Annual Premium
13,500	8,775	$98.54	6,750	$247.66	4,725	$257.42
27,000	17,550	$197.09	13,500	$495.32	9,450	$514.84
40,500	26,325	$295.63	20,250	$742.97	14,175	$772.25

For 80+ rates please contact the plan administrator at 1-877-492-3862.
The amount of Life Insurance for Spouses of Active Members will reduce by 65% when the member reaches age 65; by 50% at age 70; by 35% at age 75; and by 20% at age 80. The above rate chart outlines these coverage reductions and the amount of insurance that you may elect as a new enrollee.

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date (but not more than once in any 12-month period) and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insurance under this group policy. For example, a class of insureds is a group of people all with the same issue age, and tobacco/nicotine use. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the California School Employees Association.

Semi-Annual Premium for Retired Member Dependent Life

$4.32

The above premium covers the eligible spouse and dependent children of the Retired Member regardless of how many are insured.