GUARANTEED ACCEPTANCE – Limited Time Offer
Group Term Life/AD&D Enrollment Form for Members of the CIVIL SERVICE EMPLOYEES BENEFIT ASSOCIATION

New Hires must apply within 45 days of Hire. Grade Level Changes must apply within 60 days of change

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Complete this form and return to:
CSEBA Plan Administrator,
Wright & Co.
706 Philadelphia Pike, Suite 1
Wilmington, DE 19809
Toll Free 1-800-424-9801

MEMBER INFORMATION: [PRINT IN INK OR TYPE ALL ANSWERS] **Group Policy: G-29155-0 Certificate No.__________**

____ ________________________
Last Name First Initial Social Security Number

____
Billing Address: Street City State/Province Zip Code

____
Home Address: Street City State/Province Zip Code

_________________________________ (____)______________ (____)_______________ (____)_________________________
e-Mail Address Day Time Phone Number Evening Phone Number Day Fax Number

Date of Birth ____/____/_____ (MM / DD / YYYY) Height _____ft_____in. Weight ________lbs. Sex: ❒ Male ❒ Female

Marital Status: ❒ Married ❒ Divorced ❒ Domestic Partner*(Submit a completed Declaration of Domestic Partnership Form – Not Applicable in Oregon)
Maiden Name________________ ❒ Single ❒ Civil Union* *Eligibility is determined by State Law

Are you an eligible Federal Government Employee working full-time (17.5 or more hours per)? ❒Yes ❒ No

Date of Hire: ___/___/____ (MM / DD / YYYY) Agency Name______________________________________ GS / SES Grade Level Level _____________

Date of Grade Level Change ___/___/_____ (MM / DD / YYYY) New GS/SES Grade Level _________ Annual Income $_________________________

Occupation_________________________ How did you hear about Wright? ____

Are you presently insured by any CSEBA Insurance Plan? ❒Yes ❒ No If yes, details: _________________________________
____

Do you intend to reside outside the U.S. or Canada in the next 12 months? ❒ Yes ❒ No If yes, Country __________ How Long?____

INSURANCE REQUESTED: (Refer to your certificate, or www.wrightusa.com for eligibility, options, and coverage descriptions)

I HEREBY APPLY FOR THE FOLLOWING GROUP LIFE/AD&D COVERAGE(S): ❒ New Coverage ❒ Additional Coverage

NOTE: If you are increasing or altering present coverage in any way, indicate the Total Amount of Coverage, not just the increased amount.
You must already be insured to qualify for the GS Level Grade Change increases which are limited to the lesser of your current annual salary (rounded to the next higher $1,000) or a maximum of a $50,000 increase.

Member Coverage Amount (up to your annual income rounded to the next higher $1000)………. $______________________

INSURANCE REPLACEMENT – RESIDENTS OF NEW YORK: I have read the Important Replacement Information below. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?
Member ❒Yes ❒ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy?
Member: ❒Yes ❒ No

NEW YORK RESIDENTS - 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.

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BENEFICIARY DESIGNATION: I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. 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)*

Beneficiary's Name:	Complete Address	Relationship	Social Security #	%
Beneficiary's Name:	Complete Address	Relationship	Social Security #	%

I **understand** that insurance will not be effective until the first day of the month on or following acceptance of my enrollment form and receipt of the initial premium. If a person is hospitalized on the date insurance is to take effect, such insurance will take effect after the date of discharge.

By signing and dating this enrollment form, the member **requests** the insurance indicated; the member and any person proposed for insurance **attest to** having read the Fraud Notices indicated on the attached; and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member Signature X ____

(PLEASE SIGN AND DATE IN INK) DATE

PAYMENT OPTION SELECTION: *Choose only one*

❒ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** ❒ Semi-Monthly ❒ Monthly ❒ Quarterly

I request and authorize CSEBA Insurance Administrators to make withdrawals against the account specified on the attached ❒voided check ❒ statement savings account deposit slip, 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 plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X____ ______________________

Signature(s) as required on checks issued against this account Date

❒ **OPTION 2: QUARTERLY DIRECT BILL** (Renewals are billed each January, April, July and October)

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Have all questions been answered?

If you have made corrections or strikeouts, the member must initial them.

Return the completed application to the CSEBA Plan Administrator:

Wright & Co.
706 Philadelphia Pike, Suite 1
Wilmington, DE 19809
Toll Free 1-800-424-9801

Residents of Puerto Rico should mail applications to:

Global Insurance Agency
P.O. Box 9023918
San Juan, Puerto Rico 00902-3918

Fraud Notices

Please read before signing the enrollment form

FRAUD NOTICE – ***For Residents of all states except those listed below:*** 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 AR/LA/MD/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.

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 NY: *For AD&D only*, any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

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Wright & Co. ◆ Insurance Plan Administrator ◆ 706 Philadelphia Pike, Suite 1, Wilmington, DE 19809 ◆ Toll Free: 800-424-9801