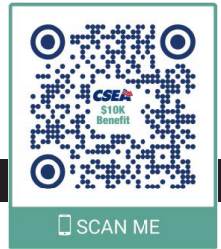




Accidental Death (AD) Beneficiary Form
Customer Number TS05050044-G
Group Policyholder Name: Civil Service Employees Association, Inc.



SECTION I – Insured Information

First Name _____ M. _____	Last Name _____	
Address – Street _____	Non-Work Email _____	Date of Birth _____
City _____	State _____ Zip _____	Non-Work Phone Number _____
Job Title _____	Employer _____	SSN _____
Annual Salary/Hourly Rate _____	NYS ID # or Employee ID# _____	CSEA Local/Unit # _____
Work Address _____	Full Time _____ Part Time _____	

SECTION II – Beneficiary Information Complete the section that pertains to the type of beneficiary you are designating.

PRIMARY BENEFICIARY - Your first choice to receive your life insurance proceeds in the event of your accidental death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name _____ M. _____	Last Name _____	Date of Birth _____
Address – Street _____		Phone Number _____
City _____	State _____ Zip _____	SSN _____
Relationship to Member _____	% Share _____	

You **MUST** designate at least one primary beneficiary. A person may **only be listed once**. The sum **MUST equal 100%**. Dollar amounts, fractions & decimals will not be accepted.

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name _____ M. _____	Last Name _____	Date of Birth _____
Address – Street _____		Phone Number _____
City _____	State _____ Zip _____	SSN _____
Relationship to Member _____	% Share _____	

The sum of the Primary & Contingent Beneficiary percentages **MUST each equal 100%**. Dollar amounts, fractions & decimals will not be accepted.

If you need more space for additional beneficiaries, use the back of this form. For living trust or estate, visit cseainsurance.com/Products-Forms/Term-Life to download the full form and submit to CSEA, Inc., ATTN: Insurance Dept., 143 Washington Ave., Albany, NY 12210.

SECTION III – Signature & Attestation

I hereby authorize the Civil Service Employees Association, Inc. (CSEA), Local 1000 AFSCME, AFL-CIO, to be my exclusive representative for collective bargaining and therefore revoke any other representative that I may have previously designated. I also hereby authorize the fiscal or payroll officer of my employer to deduct CSEA dues from my salary in the amount certified by CSEA in this and succeeding years of my employment and membership. Dues, contributions, or gifts to CSEA are not tax deductible as charitable contributions. However, they may be deductible as ordinary and necessary business expenses.

I may revoke this authorization by sending a letter stating my intent to resign, along with my name, address, telephone number, CSEA ID number, and signature by United States Postal Service First Class Mail, to: CSEA Statewide Secretary, Civil Service Employees Association, Inc., 143 Washington Ave., Albany, NY 12210.

I hereby revoke any previous beneficiary designations, and I designate the person, people, or entity named in Section II as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

I acknowledge that I am a Member in good standing, which entitles me to this \$10,000 AD policy.

Member Name (Please print) _____	Member Signature _____
Date (Must be date form was completed) _____	
<input type="checkbox"/> By checking this box, I consent to receive calls (including recorded or autodialed calls or texts) at my cell phone number from CSEA and its affiliated labor organizations on any subject matter. You may modify your preference by calling CSEA at 1-800-342-4146 or visiting the CSEA website at cseany.org .	

