New York State Governor's Office of Employee Relations
Division of Managerial/Confidential Affairs-Group 23900

Management/Confidential Group Life Insurance Transaction Form

New York State Department of Civil Service
0Employee Benefits Division

TYPE OR PRINT WITH BALLPOINT PEN

1. Last Name	First Name	M.I.	4. Dept. or Agency	5. Div. or Inst.	6. Agency Code	7. Line Item
2. Number and Street			8. Social Security Number	9. Date of Birth (Mo./Day/Year) / /	10. ☐ Male ☐ Female	11. Negotiating Unit
3. City, Town or Village	State	Zip Code	12. Annual Salary	13. Pay Period ☐ Adm. Bi-Weekly ☐ Inst. Bi-Weekly		

14. Check One: ☐ **New Application** ☐ **Change in Coverage** ☐ **Declination of Coverage** ☐ **Other**

Any Increase in coverage will not be effective until proof of insurability is accepted by the insurance carrier. **Important—For new application or change in coverage, one block must be checked in sections 15, 16 & 17**

15. **Personal Life insurance and Accidental Death and Dismemberment Insurance**

I Request:

- A. $ 5,000 ☐
- B. $10,000 ☐
- C. $15,000 ☐
- D. One Times Salary* ☐
- E. Two Times Salary* ☐
- F. Three Times Salary* ☐
- G. Four Times Salary* ☐
- H. Five Times Salary* ☐
- • Cancel Coverage ☐
- • No Change in Option ☐

* Total amount rounded to next higher $1,000 if not an even $1,000

16. **Dependent Life Insurance**

Check Box of Coverage Desired

I Request:

- A. Spouse Only ☐
- B. Spouse and Children* ☐
- C. Children Only* ☐
- D. None ☐
- • No Change ☐

If this is a change from your original request, such as a newly eligible dependent or loss of eligibility, please enter the Date and Reason for Change below:

____

____

____

____

This coverage is not available unless employee also has personal life insurance.

* The signature of the natural parent is required when enrolling a stepchild. (See Box 22.)

17. **Cost of Coverage** (Employee Computation)

1. Personal Smoker ☐
   Non-Smoker ☐ $ ________
2. Dependent $ ________

Total Bi-Weekly Cost $ ________

* Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months.

Change of Name	FROM	18. Last Name	First Name	M.I.	TO	19. Last Name	First Name	M.I.	20. If change is due to marriage, give date (Mo./Day/Yr.) / /

21. **Designation of Beneficiary**

Complete A; Complete B for sole beneficiary only, your estate will be the contingent beneficiary. For other types of designation, obtain appropriate forms from your Benefits Administrator and complete C.

A. ☐ Designation of Initial Beneficiary
☐ No Change in Beneficiary
☐ Change in Beneficiary

B. Designation of Sole Beneficiary Only

Last Name	First Name	M.I.
Number and Street		
City, Town or Village	State	Zip Code
Relationship	Date of Birth	☐ Male ☐ Female

C. Alternative Beneficiary Designation

Section B must be blank

☐ Form Attached

22. To Comptroller of the State of New York

I hereby apply for the group life insurance coverage indicated above and rescind any previous application for group life insurance offered by the State of New York to Managerial/Confidential Employees and other eligible employees. If I am applying for dependent coverage for my stepchild, the natural parent's signature also appears below. I designate the person named in Block 21 as my beneficiary. I have received and read a copy of the current announcement describing such insurance. I hereby authorize you to deduct from my salary or retirement allowance the entire cost of premium or subscription charges for coverage under the group insurance plan for Managerial/Confidential Employees authorized by the provisions of Section 158 of the Civil Service Law and to transmit the sums so deducted to the company carrying such insurance. You are further authorized to make any necessary changes or adjustments in said deductions as may be necessary from time to time because of changes in my rate or rates or in my coverage. This authorization shall be effective until revoked by me by written notice.

Date __________ Signature ____________________

Date __________ Signature of Natural Parent ____________________

23. **Employing Agency Use:**

A. Date first eligible for Managerial/Confidential Coverage ____ Month ____ Day ____ Year

B. Date application received ____ Month ____ Day ____ Year

C. If late enrollee, date approved by insurance carrier ____ Month ____ Day ____ Year

D. Effective date of coverage or coverage change ____ Month ____ Day ____ Year

E. I hereby certify that I have personally verified the salary, age and eligibility of the above applicant.

Signature ____________________ Date __________

Title ____________________

24. **Department of Civil Service Use:**

Approved by: Signature ____________________ Date __________

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