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

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TYPE OR PRINT 2. Number and Street		T. T. T.							1 7 cm		
Second South Number		1. Last Name	First Name		M .I.	4. Dept. or Agency	5. Div. or Inst.	6. Agency Code	7. Line Item		
Per	WITH	2. Number and Street				8. Social Security Number	9, Date of Birth (Mo./Day/Year)		11. Negotiating Unit		
14. Clock Clone:		3. City, Town or Village		State	Zip Code	12. Annual Salary					
Any increase in coverage will not be effective until proof of insurance and Accidental Death and Dismemberment Insurance 15. Personal Life insurance and Accidental Death and Dismemberment Insurance 17. Despendent Life Insurance 17. Cost of Coverage Cemples Control ross of eligibility, please enter the Date and Reason for Change below. 1. Personal Smoker 1. Personal	14. Check One		□ New Application	[] Ch	ongo in Coversus				Bi-Weekly		
Personal Life insurance and Accidental Death and Dismemberment Insurance Request			e effective until proof of insurability is	accepted by	ange in Coverage the insurance carrier. I	Declination of Upperlant—For new application or	Coverage U O	ther k must be sheeked in a			
Personal Lite insurance and Accidental Dath and Dismemberment Insurance Check Box of Coverage Desired Request: Lequest: Le	15.				16. Dependent L	ife Insurance If this is a chan	one from your original				
A. \$ 5,000 F. Three Times Salary* B. \$5,000 F. Three Times Salary* C. Children Only* C. Children		Person Accidental Death	al Life insurance and and Dismemberment Insurar	ice		rage Desired request, such a dent or loss of	as a newly eligible depen- eligibility, please enter the				
A. \$ 5,000	I Request:				I Request:	Date and Reas	on for Change below:	1 Personal Smoker			
B. \$10,000					A. Spouse Only						
C. \$15,000					B. Spouse and Ch	ildren* 🗌		Non-Smoker	⊔ Ф		
D. One Times Salary*			G. Four Times Salary*		C. Children Only*			2 Dependent	¢		
E. Two Times Salary*			H. Five Times Salary*		D. None			2. Dopondon	Ψ		
This coverage is not available unless employee also has personal life insurance. * Total amount rounded to next higher \$1,000 if not an even \$1,000 * Total amount rounded to next higher \$1,000 if not an even \$1,000 * The signature of the natural parent is required when enrolling a stepchild. * This coverage is not available unless employee also has personal life insurance. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Total amount rounded to next higher \$1,000 if not an even \$1,000 * This coverage is not available unless employee also has personal life insurance. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Total amount rounded to next higher \$1,000 if not an even \$1,000 * This coverage is not available unless employee also has personal life insurance. * The signature of the natural parent is required when enrolling a stepchild. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months. * Use non-smoker rates if you have not smoke an pleasance over segonal decided above and rescind any previous application for group life insurance overage indica	D. One Ti	mes Salary*	 Cancel Coverage 		No Change		ė	Total Bi-Weekly Co	st \$		
Total amount rounded to next higher \$1,000 if not an even \$1,000	E. Two Ti	mes Salary	 No Change in Option 		71	· · · · · · · · · · · · · · · · · · ·					
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 Relationship Date of Birth Date of Relative and other ecicled and ober and other ecicle					* The signature of the natural parent is required when enrolling a stepchild. smoked cigarettes, cigars or						
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 Relationship Date of Birth Date of Birth Date application stypes of designation received A. Date first eligible for Managerial/Confidential Coverage Month Day Year B. Designation of Sole Beneficiary only of Initial Beneficiary only of Initial Beneficiary I hereby apply for the group life insurance coverage indicated above and rescind any previous application for group life insurance coverage indicated above and rescind any previous application for group life insurance coverage indicated above and rescind any previous application for group life insurance coverage indicated above and rescind any previous application for group life insurance coverage indicated above and rescind any previous and therefore the for other for group life insurance coverage indicated above and rescind any previous application for group life insurance coverage indicated above and rescind any previous and therefore the for other for group life insurance coverage indicated above and rescind any previous and therefore the for other for group life insurance offered by the State of New York to Managerial/Confidential Employees and other for group life insurance offered by the State of New York to Managerial/Confidential Employees and other eligible employees. If am applying for dependent coverage for my stepchild, the natural parent's signature active active and to restrict the eligible employees. If am applying for dependent coverage for my stepchild, the natural parent's signature active leligible employees. If a managerial/Confidential Employees and other active leligible employees. If am applying for dependent coverage for my stepchild, the natural parent's signature active lelight employees and other active leligible employees. If a manageri	of Name O			M	T			. If change is due to marriage, g	give date (Mo./Day/Yr.)		
B. Designation of Sole Beneficiary Only of Initial Beneficiary Beneficiary Beneficiary No Change in Beneficiary Change in Beneficiary Relationship Date of Birth Date of Birth A. Date first eligible for Managerial/Confidential Coverage Month Day Year B. Designation of Sole Beneficiary Only of Not Relationship B. Designation of Sole Beneficiary Only on Sole Beneficiary On Sole on Sole Beneficiary Only on Sole Benefici	Complete A; Co	mplete B for sole bene	eficiary only, your estate will be the	contingent strator and	beneficiary, For other complete C.	I hereby apply for the group lift for group life insurance offered	fe insurance coverage indicated d by the State of New York to Ma	anagerial/Confidential Em	ployees and other		
Of InItial Beneficiary Beneficiary Beneficiary No Change in Beneficiary Change in Beneficiary Beneficiary City, Town or Village State Beneficiary Relationship Date of Birth A. Date first eligible for Managerial/Confidential Coverage Month Day Year Beneficiary A. Date application received A. Date application received Last Name First Name M.I. Beneficiary Designation Section B must be blank Beneficiary Designation Section B must be blank Beneficiary City, Town or Village State Zip Code Beneficiary Relationship Date of Birth Date of Birth Date of Birth Date of Month Day Year Title Title Title A. Date application received Last Name First Name M.I. Beneficiary Designation Section B must be blank of the Civil Service Law and to transmit the sums so deducted to the company carrying 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. 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. I hereby certifement allowance the entire cost of premium or subscription of Section 158 of the Civil Service Law and to transmit the sums so deducted to the company carrying such insurance. I hereby certiferent allowance the entire cost of premium or subscription of Section 158 of the Civil Service Law and to transmit the sums so deducted to the company carrying such insurance. I hereby certiferent allowance the entire cost of charges in my rate or rates or in my coverage. This authorization of the Civil Service Law and		tion B. [Designation of Sole Beneficiary	Only	C. Alternative	eligible employees. If I am app also appears below, I designa	plying for dependent coverage for te the person named in Block 21	or my stepchild, the natura 1 as my beneficiary. I hay	al parent's signature e received and read		
No Change in Beneficiary Change in Beneficiary City, Town or Village Relationship Date of Birth A. Date first eligible for Managerial/Confidential Coverage B. Date application received Number and Street Section B must be blank Section B must be blank Male Form Attached Section B must be blank Male Form Attached Section B must be blank Male Form Attached Signature Date Signature of Natural Parent E. I hereby certify that I have personally verified the salary, age and eligibility of the above applicant. Signature Date Title Title Title			First Name	M.I.	,	a copy of the current announce salary or retirement allowance	ement describing such insurance the entire cost of premium or s	e. I hereby authorize you ubscription charges for co	to deduct from my		
Change in Beneficiary City, Town or Village State Zip Code Form Attached Date of Birth Date of Birth Date of Birth Date of Birth Date Signature Date Signature Date Signature Signature of Natural Parent					must be	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					
Relationship Date of Birth Male Female Date Signature of Natural Parent	_		e State	Zip Code	☐ Form	shall be effective until revoked	by me by written notice.				
23. Employing Agency Use: A. Date first eligible for Managerial/Confidential CoverageMonthDayYear B. Date application receivedMonthDayYear TitleTitle		Relationship	Date of Birth								
A. Date first eligible for Managerial/Confidential CoverageMonthDayYear B. Date application receivedMonthDayYearTitle	23. Employing	g Agency Use:						e and eligibility of the ab	ove applicant		
	A. Date first	t eligible for Manageri	al/Confidential Coverage	Month	Day Year				ото арриоана.		
	B. Date app	olication received		Month	Day Year	Title					
	C. If late en	rollee, date approved	by insurance carrierI	Month	Day Year		vice Use:	· · · · · · · · · · · · · · · · · · ·			
D. Effective date of coverage or coverage changeMonth Day Year Approved by: Signature Date Date	D. Effective	date of coverage or o	coverage changeI	Month	Day Year	Approved by: Signature		Date			