Accidental Death (AD) Beneficiary Form
Customer Number TS 05050044-G

Group Policyholder Name:
Civil Service Employees Association, Inc.

SECTION I – Insured Information

First Name ____ M. ____ Last name ____ Date of Birth ____

Address – Street ____ Non-Work Email ____ Phone Number ____

City ____ State ____ Zip ____ SSN ____

SECTION II – Beneficiary Information

Complete the section that pertains to the type 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%.**

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL of 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 equal 100%.** Dollar amounts, fractions & decimals will not be accepted.

If you need more space for additional beneficiaries use back of this form. For living trust, or estate, visit www.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, and CSEA ID number, by United States Postal Service First Class Mail, to: CSEA Statewide Secretary, CSEA, Inc., 143 Washington Ave., Albany, NY 12210.

I hereby revoke any previous 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.

☐ **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 preferences by calling CSEA at 1-800-342-4146 or visiting the CSEA website at cseany.org.**

I acknowledge that my membership entitles me to this $10,000 AD policy.

Member Name (Please Print) ____ Member Signature ____

Date (Must be date form was completed) ____