



EMPLOYEE INFORMATION

1. Last Name		First Name		MI	2. Social Security Number		3. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
4. Date of Birth		5. Telephone Number: (       )			6. <input type="checkbox"/> Non-Smoker <input type="checkbox"/> Smoker Use non-smoker rates if you have not smoked cigarettes, cigars or a pipe within the past 12 months			
7. Street Address					City	State	Zip Code	
8. Department or Agency			9. Agency Code		10. Negotiating Unit		11. Annual Salary	

12. CHOOSE ONE

**New Application**     **Late Application**     **Declination of Coverage**     **Other:** \_\_\_\_\_

\*Must also submit a PS934.1 Beneficiary Form with any new enrollment

**Change in Coverage - Reason:** \_\_\_\_\_    **Effective Date:** \_\_\_\_\_

Any Increase in coverage will not be effective until proof of insurability is accepted by the insurance carrier.  
For new application or change in coverage, one block must be checked in section 13.

13. COVERAGE OPTIONS

<p><b>A. Personal Life Insurance and Accidental Death &amp; Dismemberment Insurance</b></p> <p><input type="checkbox"/> \$ 5,000                      <input type="checkbox"/> Three Times Salary*</p> <p><input type="checkbox"/> \$10,000                      <input type="checkbox"/> Four Times Salary*</p> <p><input type="checkbox"/> \$15,000                      <input type="checkbox"/> Five Times Salary*</p> <p><input type="checkbox"/> One Times Salary*        <input type="checkbox"/> Cancel Coverage</p> <p><input type="checkbox"/> Two Times Salary*</p> <p>* Total amount rounded to next higher \$1,000 if not an even \$1,000</p>	<p><b>B. Dependent Life Insurance</b> Enter dependent information in box 14</p> <p><input type="checkbox"/> Spouse Only</p> <p><input type="checkbox"/> Spouse and Children</p> <p><input type="checkbox"/> Children Only</p> <p><input type="checkbox"/> Cancel Spouse Coverage</p> <p><input type="checkbox"/> Cancel Dependent Coverage</p> <p>This coverage is not available unless the employee also has personal life insurance.</p>
--	--

14. DEPENDENT INFORMATION

Last Name	First Name	MI	Relationship	Date of Birth	Sex	Address (if different)	Social Security Number

15. ATTESTATION

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. I have completed the PS 934.1, Designation of Beneficiaries form. 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.

**For a late application or an increase in coverage, please select; I have received the Statement of Health:**  Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Attach the Beneficiary Designation Form (PS-934.1) when you submit this application.

**Personal Privacy Protection Law Notification**

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

**EMPLOYING AGENCY USE**

Enter the following dates below:

- **Date first eligible for Managerial/Confidential Coverage** \_\_\_\_\_
- **Date application received** \_\_\_\_\_
- **If late enrollee, date approved by insurance carrier** \_\_\_\_\_
- **Effective date of coverage or coverage change** \_\_\_\_\_

I hereby certify that I have personally verified the salary, age and eligibility of the above applicant and provided a Statement of Health form if the enrollee responded yes in Box 15.

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**DEPARTMENT OF CIVIL SERVICE USE**

Approved by

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



Group Term Life Insurance Beneficiary Designation

Use this form to name the persons or entities you want to receive your life insurance proceeds after your death.

Primary Policy Holder (NYS Employee)

Form for Primary Policy Holder with fields: Last Name, First Name, MI, Date of Birth, Social Security Number, Phone Number, Street Address, City, State, Zip Code.

Beneficiaries

Use this portion of the form to name the persons or entities you want to receive your life insurance proceeds after your death and include what percentage each will receive. In each beneficiary box you must check a box to determine if they are to be designated as a Primary or Contingent beneficiary.

- Primary beneficiaries are your first choice to receive the insurance proceeds after your death. If a primary beneficiary dies before you, their share(s) will be divided equally between the remaining primary beneficiaries.
Contingent beneficiaries receive the insurance proceeds only if all of the primary beneficiaries are deceased at the time of your death.

If a beneficiary dies before you, we will divide their share(s) equally between the remaining beneficiaries. The total proceeds for all primary beneficiaries must equal 100% and all contingent beneficiaries must equal 100%.

Beneficiary 1 form with checkboxes for Primary and Contingent, and a field for Proceeds assigned to this person: \_\_\_\_\_%

Beneficiary 2 form with checkboxes for Primary and Contingent, and a field for Proceeds assigned to this person: \_\_\_\_\_%

Beneficiary 3 form with checkboxes for Primary and Contingent, and a field for Proceeds assigned to this person: \_\_\_\_\_%

(Continued on Page 2)

<b>Beneficiary 4:</b> <input type="checkbox"/> <b>Primary</b> <input type="checkbox"/> <b>Contingent</b>				<b>Proceeds assigned to this person:</b> _____ %	
Last Name		First Name		MI	
Date of Birth	Social Security Number	Phone Number	Relationship to Insured		
Street Address		City	State	Zip Code	

In lieu of or in addition to naming individual(s) as beneficiaries, you may also allocate all or a percentage of the insurance proceeds to your estate, a testamentary trust created in your last Will and Testament, a living Trust, or a charity or organization of your choosing.

<b>Estate, Trust or Charity/Organization:</b> <input type="checkbox"/> <b>Primary</b> <input type="checkbox"/> <b>Contingent</b>				<b>Proceeds assigned:</b> _____ %	
Name of the entity					
Contact Name			Phone Number		
Street Address		City	State	Zip Code	
<b>If a Trust, fill out the following:</b>					
Trust Date			Trust Tax ID Number		
Trustee Last Name		First Name		MI	

**The total proceeds for primary beneficiaries must equal 100% AND the total proceeds for contingent beneficiaries must equal 100%.**

**Personal Privacy Protection Law Notification**

The information you provide on this application is requested in accordance with Section 163 of New York State Civil Service Law for the principal purpose of administering the New York State Health Insurance Program. This information will be used in accordance with Section 96 (1) of the Personal Privacy Protection Law, particularly subdivisions (b), (e) and (f). Failure to provide the information requested may interfere with our ability to comply with your request. This information will be maintained by the Director, Employee Benefits Division, Department of Civil Service, Albany, NY 12239; (518) 473-1977. For information relating only to the Personal Privacy Protection Law, call (518) 457-9375.

**By signing below, I hereby revoke any previous designations, and I designate the person, people, or entity named herein as beneficiaries.**

Check if you are completing and signing this form as agent for the insured under a valid Power of Attorney. Please submit a copy of the Power of Attorney with this beneficiary form.

**Name (Please Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_