PSC-CUNY Welfare Fund

APPLICATION FOR GROUP CATASTROPHE/EXCESS MAJOR MEDICAL INSURANCE

For office use only:
14145/14146/1001/43658
14220/14221/1002/43658
18926/18927/1003/43658
18910/18911/1004/43658

Please print or type all information requested.
NOTE: If you have previously applied for insurance, a copy of that application must be attached.

TO APPLY:
Send this completed form with your premium check payable to:
ADMINISTRATOR
PSC-CUNY GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-0374

QUESTIONS?
Call: 1-800-503-9230
customerservice@marshpm.com

The United States Life Insurance Company in the City of New York

Member's Full Name _____
First Middle Last

Home Address _____

Date of Birth _____ Place of Birth _____ Height ____ft. ____in. Weight _____lbs.

Sex: Male ☐ Female ☐ Social Security Number _____

CHOOSE YOUR COVERAGE, INCLUDING DEPENDENTS, DEDUCTIBLE AND PAYMENT METHOD

1. Please check the coverage you desire (check only one):
☐ Member Only ☐ Member and Spouse ☐ Member and Children ☐ Member, Spouse and Children
2. Your Deductible: $10,000
3. Your payment method ☐ Monthly (Automatic Check Withdrawal) ☐ Semiannually (Direct Bill) ☐ Payroll Deduction
4. Do you, and your dependents, if applying, have a basic major medical plan? ☐ Yes ☐ No
If not, you are not eligible for this coverage.

LIST ELIGIBLE DEPENDENTS YOU WISH TO INSURE (MEMBER MUST BE INSURED TO INSURE DEPENDENTS

Name	Age	Date of Birth (Mo/day/yr)	Place of Birth	Height ft. in.	Weight lbs.	Sex M F
Spouse/Domestic Partner						
Child						
Child						

(Use separate sheet, if necessary, for additional children)

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE REQUIRED →

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the insurance company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier for medical care, advice, treatment or supplies for any physical or mental condition. This includes the information obtained in connection with the preparation or procurement or any investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid transmission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that this will be used by the insurance company solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not effect an action which the insurance company has taken in reliance upon this authorization. I understand that this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full while there is no change in the insurability or health of such person from that stated in the application.

ATTESTATION

To the best of my knowledge and belief, I attest that during the five (5) years immediately prior to completing this Application, I or anyone else for whom coverage is being requested have not been treated for or diagnosed as having, heart disease, kidney disease, cancer, any immune disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC), diabetes, neurological disease, mental or nervous dysfunction, alcohol or drug dependency, pulmonary, liver and circulatory disease.

EXCEPTIONS: _____

I understand that the insurance applied for will take effect on the date specified by The United States Life Insurance Company in the City of New York provided I, and those other persons indicated above for whom application is made, have not been hospitalized on that date. It is also understood that a sickness or injury caused by a pre- existing condition is not covered until treatment, care or advice has not been received for 12 consecutive months after coverage has been in force or after coverage has been in force for 24 straight months. A pre-existing condition is one for which medical treatment, care or advice was received within the 12 months just prior to the date the person's coverage takes effect.

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (Fraud provisions vary by state.)

Signature of Member _____ **Date** _____

Signature of Spouse/Domestic Partner _____ **Date** _____
(If applying for insurance)

E-216,170
AG-6499

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. United States Life Insurance Company in the City of New York, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

United States Life Insurance Company in the City of New York, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Domestic Partnership Declaration

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.
2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).
3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):
   - ☐ Common ownership of a motor vehicle.
   - ☐ Joint bank or credit accounts.
   - ☐ Assignment of durable power of attorney in favor of one another.
   - ☐ Common ownership of real estate or common leasehold interest in property.
   - ☐ Joint ownership or holding of stocks, bonds, or other investments.
   - ☐ Execution of will naming each other as executor and/or beneficiary.
   - ☐ Designation as beneficiary under the other's retirement or pension benefits account.
4. That the undersigned member and domestic partner (check one):
   - ☐ have filed a domestic partner declaration with the (City/Council/Borough) of_____ and that such domestic partner declaration remains in effect (attach copy of declaration).
   - ☐ do not reside in a jurisdiction which provides for the registration of domestic partnership declarations.
5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.
6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.
7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability which would prevent them from making this affidavit.
8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.
9. That the undersigned member and domestic partner are not related by blood in any degree which would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature_____ **Date**_____

Soc. Sec. No._____

Domestic Partner's Signature_____ **Date**_____

Soc. Sec. No._____

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below. ***Remember to include your first premium and a blank voided check with your application.***

Bank Name: _____

Bank Address: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____ **Date** _____

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$2,000,000 Catastrophe Major Medical Insurance Plan

FOR PSC-CUNY WELFARE FUND MEMBERS AND THEIR FAMILIES

Includes convalescent home & home health care benefits, private duty nursing, and more!

The PSC-CUNY Welfare Fund Catastrophe Major Medical Insurance Plan is now more important than before!

Why? There are really two main reasons.

#1 Medical costs will continue to increase.

#2 Your basic health insurance may not be capable of covering a catastrophic illness or accident.

If you were involved in a catastrophic accident or illness, the last thing you would want to be concerned with would be your medical and hospital expenses. Yet, many people don't realize that their health insurance may not be able to pay all the costs associated with such a major medical expense.

Most health plans (including Medicare) have a limit on the benefits they will pay. While your current plan may have a significant lifetime benefit (perhaps $1,000,000), this amount can quickly be depleted by a catastrophe.

And what if your recuperation required a stay in a convalescent center? Who would pay those bills? Without the insurance protection of a plan like the PSC-CUNY Welfare Fund Catastrophe Major Medical Insurance Plan ... you would.

The PSC-CUNY Welfare Fund Plan is designed to enhance your various City of New York coverages or Medicare. It picks up where those coverages leave off. That's why this Plan includes a $10,000 deductible (or the amount paid by your health plan, whichever is greater). **Once your deductible is met, the Catastrophe Major Medical Plan pays up to 100% of all eligible reasonable and customary expenses up to a maximum of $2,000,000 per benefit period for up to 10 years from the date the first eligible expense is incurred and used to satisfy the deductible.**

Works with your Basic Health Coverage

All applicants must be covered under a basic health insurance plan. The required basic plan is a medical insurance plan which provides benefits at least as great as the following: semi-private room and board up to 70 days; $10,000 for extra hospital services other than room and board; $25,000 for physician services; and a lifetime maximum benefit of $1,000,000. At claim time, if you do not have a basic plan equal to these benefits, any charges incurred for: the first 70 days of each hospital confinement; the first $10,000 of charges for chemotherapy, radiation therapy, physical or speech therapy; the first $25,000 of charges for physician services; and the first $2,500 of charges for out-of-hospital prescription drugs will not be covered.

IMPORTANT FEATURES

Catastrophe Coverage

The Catastrophe Major Medical Insurance Plan is DESIGNED TO HELP PICK UP ELIGIBLE EXPENSES not covered by the various City of New York Employee Benefit Programs, any other major medical, hospitalization plans or Blue Cross/Blue Shield. It even pays beyond the limits of Medicare Parts A and B. These plans may provide adequate health insurance protection, but may LIMIT BENEFITS ON A YEARLY BASIS and may LIMIT BENEFITS AGAIN as to covered charges. The $2,000,000 Catastrophe Major Medical Insurance Plan has been designed to enhance your basic policy and ease your financial concerns.

Who Is Eligible?

All members in good standing and retired members are eligible to apply for coverage for themselves and their lawful spouse/domestic partner. An insured member's unmarried, dependent children from birth to 29 years are also eligible (subject to state variations). All applicants must be covered under a basic medical plan or Medicare Parts A & B.

Effective Date

Coverage will be effective following receipt and acceptance of the written Application and applicable premium payment. The effective date for insurance will be delayed if the insured or insured dependents are unable to perform the normal activities of a person of like age and sex, with like occupation or retired status. Insurance will take effect on the day the insured resumes such activities.

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Coverage for Recurrent Conditions

You are eligible for the maximum benefit as much as $2,000,000 during one benefit period. If a period of 12 consecutive months passes in which no covered expenses are incurred, treatment for the same or related condition will be treated as a new illness with a new deductible and benefit period. If less than 12 consecutive months pass between the incurred covered expenses, treatment for the same or related condition will be treated as part of the same claim with the same benefit period and maximum limit.

Convalescent Home Benefits

Anyone at any age can require confinement in a convalescent or custodial care facility due to a non-job related injury or sickness. That's why this is an extremely important benefit to you ... a benefit that may not be included in your basic health insurance plan. Should ANY insured family member become confined as an in-patient in a convalescent or custodial care facility due to a non-job related injury or sickness, after the deductible is satisfied, the Plan pays eligible expenses for room and board, general convalescent care services and supplies up to $400 per week — up to 52 weeks (lifetime maximum). Confinement must begin within fourteen days following hospitalization of at least three days and must be due to the injury or sickness which required the hospitalization.

A Convalescent Home **MEANS** a licensed institution that has on its premises — organized facilities to care for and treat its patients; a staff of physicians to supervise such care and treatment; and a registered nurse on duty at all times. A Convalescent Home **DOES NOT** mean a place, or part of one, which is used mainly for — the aged; alcoholics; drug addicts; or persons with mental, nervous or emotional disorders.

Home Health Benefits

After the deductible has been satisfied the Plan will pay the reasonable and customary charges for covered home health care treatment up to 300 visits in any period of 12 consecutive months. These services must be provided by a certified home health care agency. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health aide services will be considered one home health care visit. Home health care is in lieu of confinement in a hospital or skilled nursing facility.

Private Duty Nursing Services

Medically necessary private duty nursing services by a registered or licensed practical nurse while in a hospital or at home — up to $120 maximum per 8-hour shift ($360 maximum per day) up to a lifetime maximum of $35,000 per insured after the satisfaction of your deductible.

Common Disaster Provision

If more than one insured family member is injured in the same accident ... or contracts the same contagious disease within 30 days ... only one deductible needs to be satisfied and each insured family member will still be eligible for up to $2,000,000 in benefits for up to 10 years from the date the covered expenses were first incurred against the deductible.

Pays Up To 100% Of Eligible Reasonable And Customary Expenses After Your Deductible And Your Basic Plan Benefits

- Hospital charges for daily semi-private room and board and intensive care.
- Miscellaneous hospital services and operating room charges.
- Treatment by a licensed physician — in a hospital, at home or in the office.
- Dental care, treatment or surgery if natural teeth are injured by a covered non-job related accident which occurs while insured: and such services are rendered within 12 months of the accident *or* they are made by a hospital while hospitalized.
- X-ray, physiotherapy (by a licensed physiotherapist) or laboratory services for diagnosis and treatment.
- Anesthetic and its administration.
- Any form of ambulance service (including airplane, railway, etc.) to and from any hospital for treatment prescribed by a licensed physician ... as much as $2,000 lifetime maximum per insured.
- Prescription drugs, casts, splints, braces, trusses or crutches both in and out of the hospital.
- Oxygen and rental of equipment for its administration and rental of wheelchairs or hospital beds.
- Rental of mechanical equipment for treatment of respiratory paralysis; rental of mechanical equipment for medical or surgical treatment.
- PLUS ... Expenses for room and board, general nursing care services and supplies for convalescent or custodial care as an in-patient in a convalescent home up to $400 per week for up to 52 weeks (lifetime maximum).

Your Deductible

The $2,000,000 Catastrophe Major Medical Insurance Plan includes a $10,000 deductible (or the amount paid by your health insurance, whichever is greater). When insured, eligible reasonable and customary expenses count toward your deductible in full. Even those eligible expenses paid for by your health insurance policy as well as those paid out of your own pocket count toward meeting your deductible.

Once you become insured under the Plan, you have up to one full year to satisfy your deductible beginning with the date the first eligible expense is incurred for a covered injury or sickness and used to satisfy the deductible. And, once the deductible is satisfied during any one benefit period, benefits are payable for eligible expenses incurred for hospital-surgical-medical and convalescent care, regardless of whether or not the expenses are related to the same injury or sickness.

Payroll Deduction Option

All actively employed members are eligible to apply for this coverage through payroll deduction. Simply select the payroll deduction option on the enclosed Application and return it with the Payroll Deduction Authorization Card. Your premiums will then be deducted over 26 pay periods.

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Pension Deduction Option

All retired members who are in the Teachers Retirement System (TRS) or the Teachers Insurance Annuity Association (TIAA) are eligible to apply for this coverage through pension deduction. Simply select the pension deduction option on the enclosed Application and return it with the Pension Deduction Authorization Card. Your premiums will then be deducted from your pension account over 12 months each year.

Termination of Benefit Period

An insured's benefit period begins on the date the first eligible expense is incurred and will cease at the earlier of: completion of 10 years from the day eligible expenses were first incurred (a new deductible must be satisfied when the benefit period ends); two million dollars have been paid; the insured recovers; after 24 months from the date the first eligible expense is incurred if 90 consecutive days pass without at least $150 of eligible expenses being incurred; or the end of 12 consecutive months during which no charge is incurred.

Termination of Coverage

A member's coverage will terminate if the group policy is terminated; the premium is not paid when due; or he/she is no longer a member of PSC-CUNY. Coverage for dependents will terminate if the member's insurance ends; dependents' insurance ends under the group policy; the person ceases to be a dependent, or premium is not paid for the dependent when due.

Alcohol & Substance Abuse Treatment

Charges incurred for diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependency will be covered — while hospitalized; for in-patient rehabilitation in a certified or accredited alcoholic or substance abuse treatment center, up to 30 days per calendar year; for out-patient diagnosis and treatment in a certified or accredited alcoholic or substance abuse treatment center, up to 60 visits per calendar year. Up to 20 such visits may be for family members of the alcoholic or substance abuser.

Mental, Nervous or Emotional Disorder Treatment

Charges incurred for diagnosis and treatment for psychiatric, mental, nervous or emotional disorders, ailments or illnesses will be covered while hospitalized, up to 30 days per calendar year (if claimant has not already received 30 days coverage from another source); for out-patient visits, up to 30 visits per calendar year, subject to a maximum benefit of $50 per visit (the facility for such visits must have been issued an operating certificate by the commissioner of mental health pursuant to the mental hygiene law; or be operated by the office of mental health, a psychiatrist or psychologist licensed to practice or a professional corporation of such psychiatrists or psychologists); for up to three (3) psychiatric emergency visits per calendar year, subject to a benefit of $60 per visit. Benefits provided for emergency visits will reduce benefits otherwise payable for in-patient or out-patient care as described.

Exclusions

No medical care benefits will be paid by the group policy for charges incurred for treatment which: (1) is given after a person's insurance ends, regardless of when the injury or sickness occurred (however, medical care benefits may be provided in the Benefits After Insurance Ends provision of a given benefit section); (2) is not essential for the necessary care or treatment of the injury or sickness involved; (3) would be given free of charge if the person was not insured; (4) results from a war or an act of war; (5) results from intentionally self-inflicted injury; (6) is given by a person's spouse or his or his spouse's father, mother, son, daughter, brother or sister; (7) is given by a person's employer or an employee of such employer, dental care, treatment or surgery except to the extent that it is necessary to treat a non-job related injury to natural teeth, the injury is caused by an accident which occurs while insured and such services are rendered within 12 months of the accident or they are made by a hospital while the person is insured; treatment for temporomandibular joint dysfunction (TMJ) will be covered except for those charges for crowns or bridgework; eye exams to prescribe or fit corrective lenses for eyeglasses except to the extent that it is necessary to treat a non-job related injury and the injury is caused by an accident which occurs while insured, cosmetic treatment or surgery except to the extent that it is necessary to treat a non-job related injury or sickness or a congenital disease or anomaly of a dependent child resulting in a functional defect; diagnosis and treatment for alcoholism or alcohol abuse and substance abuse or substance dependence or psychiatric, mental, nervous or emotional disorders, ailments or illness except as provided herein, or for persons who are not covered under a basic plan at time of claim, the following charges will not be covered: hospital charges incurred during the first 70 days of each confinement; the first $10,000 of charges for chemotherapy, radiation therapy, physical therapy or speech therapy that would otherwise be covered; the first $25,000 of charges for physician services that would otherwise be covered.

Eligible expenses for Home Health Care do not include services or supplies not included in the insured's Home Health Care Plan as established by attending physician; and transportation services or care provided while the person is not under the continuing care of a physician. This plan does not cover charges to buy or rent air conditioners; air purifiers; motorized transportation equipment; escalators or elevators in private homes; eye glass frames or lenses; hearing aids; swimming pools or supplies for them; general exercise equipment; charges for a routine physical exam, except charges for preventive mammography and cytologic screening.

This listing is representative of the losses not covered. All the exclusions are detailed in the Certificate of Insurance.

Survivor's Coverage

Coverage continues for the covered dependent spouse or domestic partner and children of a deceased member as long as the dependents meet eligibility requirements, premiums are paid at the adjusted rates (depending on the survivor's age) and the policy remains in force.

Pre-Existing Conditions

An injury or sickness for which an ordinarily prudent person would have sought medical advice, diagnosis, care

What's Not Covered

This Plan does not cover loss caused by or resulting from any one or more of the following: intentionally self-inflicted injuries; war or acts of war; dental care; eye exams; cosmetic or plastic surgery; treatment for mental or nervous disorders, alcoholism or drug addiction, except as described in this brochure.

Pre-Existing Conditions

An injury or sickness for which an ordinarily prudent person would have sought medical advice, diagnosis, care or treatment within 6 months prior to the effective date of coverage, or any injury or sickness for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the effective date is a pre-existing condition. A pregnancy that exists on the effective date is also a pre-existing condition. Pre-existing conditions will not be covered until the insured has been covered under the Group Policy for 12 consecutive months. All covered accidents and sicknesses which originate after the effective date of insurance are covered immediately.

GROUP CATASTROPHE MAJOR MEDICAL INSURANCE

Economical Group Premium Rates

Note: All premiums — are based on applicant's age when insurance becomes effective and on applicant's attained age on renewal dates. Premiums increase when the insured enters a new age bracket. Premiums include a $5 processing fee. Although this is a group plan, rising trends in medical costs could result in a future premium increase on a group basis. You, however, will never be singled out for an increase in cost.

PAYROLL DEDUCTION PREMIUMS (Based on 26 Pay Periods)
$10,000 DEDUCTIBLE

Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	$1.33	$2.66	$4.63	$3.30
40–49	2.66	5.33	7.30	4.64
50–59	4.42	8.85	10.82	6.40
60–64	6.66	13.32	15.30	8.63
65 & Over	8.23	16.45	19.00	10.40

PENSION DEDUCTION & AUTOMATIC CHECK WITHDRAWAL PREMIUMS
These rates are based on 12 Monthly Payment Periods
$10,000 DEDUCTIBLE

Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	$2.89	$5.77	$10.05	$7.16
40–49	5.78	11.55	15.83	10.05
50–59	9.59	19.17	23.45	13.86
60–64	14.44	28.87	33.15	18.71
65 & Over	17.82	35.65	41.18	22.52

SEMI-ANNUAL DIRECT BILL PREMIUMS
$10,000 DEDUCTIBLE

Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	$20.76	$41.52	$72.30	51.54
40–49	41.58	83.16	113.94	72.36
50–59	69.00	138.00	168.78	99.78
60–64	103.92	207.84	238.62	134.70
65 & Over	128.34	256.68	296.52	162.18

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Applying is Easy!

1 Complete the enclosed Application. Please remember to include any eligible family members you would like to insure.

2. Indicate your billing preference:

- If choosing Payroll or Pension deduction, complete the separate authorization card.
- If choosing Automatic Check Withdrawal, complete authorization and include a check for your first monthly premium.
- If you choose semi-annual direct bill, include a check for your first semi-annual premium.
- Please make your check payable to Seabury & Smith.

30-Day Free Look

Please carefully review your Certificate of Insurance once you receive it. Show it to a family member or friend so they can review it also.

If you find that this Plan is not what you anticipated, then simply return it within 30 days to the Insurance Administrator. Any premiums you have paid will be promptly refunded and your coverage will be terminated. No questions asked.

We want you to be completely satisfied with this insurance coverage.

Administered by:

MARSH

P.O. Box 10374
Des Moines, IA 50306-0374
Call Toll-Free: 1-800-503-9230
http://www.personal-plans.com/psccuny

AR Ins. Lic. #245544
CA Ins. Lic. #0633005
d/b/a in CA Seabury & Smith Insurance Program Management

Underwritten by:
The United States Life Insurance Company in the City of New York

3600 Route 66
P.O. Box 1580
Neptune, NJ 07754-1580

The underwriting risks, financial obligations and support functions associated with the products issued by The United States Life Insurance Company in the City of New York are its responsibility. The United States Life Insurance Company in the City of New York is responsible for its own financial condition and contractual obligations.

United States Life has been awarded an A++ (Superior) rating from A.M. Best. This rating reflects United States Life's superior overall financial strength and operating performance when compared to A.M. Best's standards. The rating is current as of November 3, 2006. For the latest A.M. Best's Ratings and A.M. Best's Company Reports, please visit the A.M. Best Web site at www.ambest.com.

This brochure is a brief description of coverage underwritten by The United States Life Insurance Company in the City of New York, and is subject to the terms, conditions, exclusions and limitations of Group Policy Number E-216, 170, Form No. G-19000. See your Certificate of Insurance for details.

The availability of this offer may change. Coverage may vary and may not be available in all states.

The insurance described in this brochure meets the minimum standards for limited benefit health insurance as defined by the New York State Insurance Department. It does NOT provide basic hospital, basic medical, major medical, convalescent care, or long term care insurance as defined by the New York State Insurance Department.

IMPORTANT NOTICE ABOUT THE MEDICAL INFORMATION BUREAU

Retain for your records

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York, or its reinsurers may, however, make a brief report thereon to MIB, a non-profit membership organization of life insurance companies which operates
an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request. will supply such company with the information it may have in its files.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB files, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

The United States Life Insurance Company in the City of New York may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

CT385P-E216170P
Group Policy N. E-216, 170 April 2011
AG-4559

0000045-0000011-0000003

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Payroll Deduction Authorization (Please Print)

Member's Last Name | First Name | Middle Initial | Member's Social Security No.

Street Address | City | State | Zip | Daytime Telephone No.

Note: Your deductions for the $2,000,000 Catastrophe Major Medical Insurance Plan will be made on a 26-week schedule based on the PSC-CUNY Master Policy September 1 through August 31 policy term. Some payroll deduction amounts may be pro-rated.

To the Employer:

I hereby authorize you to deduct from each of my salary checks the deduction necessary for the purpose of PSC-CUNY Welfare Fund $2,000,000 Group Catastrophe Major Medical Insurance Plan underwritten by The United States Life Insurance Company in the City of New York.

I understand that this authorization may be revoked at any time by written notice to you.

Signature_____Date _____

✂ CUT HERE

PSC-CUNY WELFARE FUND
RETIREE PENSION DEDUCTION AUTHORIZATION

Return along with your application to the Insurance Administrator.

Last Name | First Name | Middle Initial | Social Security #

Street Address | City | State | Zip | Daytime Telephone No.

Retirement/Pension Number: New York City (TRS) Retirees only: T-__ __ __ __ __ __ - __
All Other Retirees (TIAA-CREF annuitants — please furnish TIAA contract number and CREF certificate number.)

Read statements below, Signature and date are required.

CHECK ONE BOX ONLY – SIGN AND DATE BELOW

☐ I belong to the Teachers' Retirement System of the City of New York (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994. The TRS is authorized to continue taking such deductions until NYSUT receives written notice from me to the contrary.

☐ I belong to the New York State Teachers' Retirement System (NYSTRS), or

☐ New York State Employees' Retirement System (NYSTRS) and I hereby request monthly withholding of union deductions from my monthly benefit as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law. NYSTRS or NYSERS is authorized to continue taking such deductions until NYSUT receives written notice from me to the contrary.

☐ I am a TIAA and/or CREF annuitant and hereby request a monthly withholding of deductions from my monthly TIAA and/ or CREF income for the purchase of coverages provided through NYSUT's Pension Advantage Program. TIAA-CREF is authorized to continue taking such deduction until NYSUT receives written notice from me to the contrary. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA-CREF, all deductions I have authorized TIAA-CREF to take on my behalf will terminate immediately.

I expressly acknowledge and understand that NYSUT will determine the exact deduction to be withheld monthly and that any questions regarding the amount will be directed by me to NYSUT. I hereby certify to TRS, NYSTRS, NYSERS or TIAA-CREF that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as provided by law.

Signature_____Date _____

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Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare.
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services.

BEFORE YOU BUY THIS INSURANCE

1. Check the coverage in **all** health insurance policies you already have.

2. For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

3. For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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