Enrollment Form for Group Insurance

Metropolitan Life Insurance Company
SBC Administration
P.O. Box 14593, Lexington, KY 40512-4593

MetLife®

Employee Name (Last, First, Middle)	Social Security Number	Customer Number	Division	Class

Your Home Address City State ZIP	Sex (M/F)	Date of Birth	Marital Status
			☐ Single ☐ Married

Your Occupation	Employer Name	Worksite Zip Code	Hire Date	Hours Worked Per Week	Salary: $
					☐ Annual ☐ Monthly ☐ Hourly

Reason for Enrollment:
- ☐ First Time Eligible
- ☐ Change in Insurance Amount Requested
- ☐ COBRA - Original COBRA Eff. Date _____ # of Mos.
- ☐ Late Enrollee **(Statement of Health form (GEF02-1 MQ) is required)**
- ☐ Change in Enrollment Other Than Insurance Amount

Coverage Requested:

Employee Coverage
- ☐ Life/AD&D (or Core): Amount $
- ☐ Enhanced Optional Life (or Buy-Up): Amount $_____ (Not to exceed 5x Salary)
- ☐ Short Term Disability
- ☐ Voluntary Short Term Disability Amount $_____ (Sold in increments of $50)
- ☐ Long Term Disability
- ☐ Dental

Spouse Coverage
- ☐ Life
- ☐ Enhanced Optional Life (or Buy-Up): Amount $ (Not to exceed 50% of Employee amount)
- ☐ Dental

Child Coverage
- ☐ Life
- ☐ Enhanced Optional Life (or Buy-Up): Amount $
- ☐ Dental

If applying for Dependent Coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)

Name (Last, First, MI)	Date of Birth	Sex (M/F)
Spouse		
Child(ren)		

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School	# of Hours

To decline coverage, complete this section: I understand that I have been given the opportunity to participate in the group insurance plan offered by my Employer. I am refusing the coverage(s) indicated at the right for which I am required to contribute. If I request Life and/or Disability Insurance after my initial enrollment period, I understand that I, or my dependents (for dependent life only), will be required to submit evidence of good health Satisfactory to MetLife. (Satisfactory to MetLife means MetLife has discretionary authority to determine eligibility.) For Dental Insurance, a waiting period may be required for certain services before expenses will be payable.

	Employee	Spouse	Child
Life/AD&D	☐	☐	☐
Enhanced Optional/Buy-Up Life	☐	☐	☐
Short Term Disability	☐		
Voluntary Short Term Disability	☐		
Long Term Disability	☐		
Dental	☐	☐	☐

Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other):
_____

For employees electing Enhanced Optional (or Buy-Up) Life and Enhanced Dependent (or Buy-Up) Life Insurance, please answer the following question:

Have you or your dependent(s) (if applicable) been Hospitalized (as defined below) during the last 90 days preceding the date of this enrollment form?

Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form (GEF02-1 MQ) is required for each person answering "Yes."

Hospitalized means admission for inpatient care in a hospital, receipt of care in a hospice facility, intermediate care facility, or long term care facility, receipt of the following treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)
Contingent Beneficiary Full Name (Last, First, Middle Initial)	**Relationship**	**Date of Birth (Mo./Day/Yr.)**	**Address (Street, City, State, Zip)**

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I understand that if life or disability coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

I also **understand** that if dental coverage is not elected, a waiting period for certain covered services must be satisfied before coverage for such services will take effect.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

In any other case, read the following warning.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime and subjects such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that he or she has read and understands the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature	Print Name	Date (Mo./Day/Yr.)
Other Signature	Print Name	Date (Mo./Day/Yr.)