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 Required)**
☐ Change in Enrollment Other Than Insurance Amount

***Beneficiary Designation for Employee Life Insurance**: I hereby name the following person(s) as beneficiary for any MetLife benefit payment upon my death. (If designating multiple beneficiaries, please use an additional enrollment form.) Unless designated otherwise, payments will be made in equal shares or all to the survivor. I reserve the right to change this designation at any time. (Dependent Life Insurance benefits are payable to the employee.)*

Primary Beneficiary	*Relationship*	*Date of Birth*

Contingent Beneficiary	*Relationship*	*Date of Birth*

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*
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 (Statement of Health Required "SOH") ☐ No
Spouse: ☐ Yes (SOH Required) ☐ No **Child:** ☐ Yes (SOH Required) ☐ No

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.

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):

_____

DECLARATION SECTION -- TO BE COMPLETED BY THE EMPLOYEE

The Employee 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. The Employee understands that this information will be used by MetLife to determine insurability.

For the Accelerated Benefits Option

I understand that my 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. I also understand that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

New York [only applies to Accident and Heath Insurance (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 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.

All other states: 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.

For Payroll Deduction Authorization by the Employee

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

I affirm the beneficiary designation shown on page 1 of this form.

_____ _____

Employee Signature (The employee must sign in all cases.) Date (Month/Day/Year)

Michigan Residents ONLY *– Sign Below* ***if Employee is enrolling for Dependent insurance on Page 1***

_____ _____

Proposed Dependent age 18 or older Date (Month/Day/Year)

_____ _____

Proposed Dependent age 18 or older Date (Month/Day/Year)

New York Residents ONLY – If enrolling stephchild(ren) for Dependent insurance on Page 1, the natural parent must sign:

_____ _____

Signature of Natural Parent (if different from employee signature above) Date (Month/Day/Year)