Enrollment Form for Group Insurance

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

SECTION TO BE COMPLETED BY EMPLOYER

Employer (Group) Name	Employee Effective Date	Customer Number	Worksite Zip	Branch

Employee Occupation/Job Title ☐ Union ☐ Non-Union ☐ Hourly ☐ Salaried ☐ Full Time ☐ Part Time Hours worked per week _______ Date of Hire(MM/DD/YY) _________

Work Status: ☐ Active ☐ Retired ☐ Disabled ☐ Re-hire – Date: ___/___/___ ☐ Layoff/Leave of Absence

Employee Earnings $ _______________
Per ☐ Week ☐ Month ☐ Year ☐ Hour
Earnings include: ☐ Bonus $ _________ ☐ Commission $ _________

☐ Original COBRA eff. Date: ___/___/___ No. of mos. ____
Surviving Spouse Soc. Sec. No. __________
Dep. Soc. Sec. No. _________ **Attach COBRA Election Form**

Reason for Enrollment: ☐ New Hire First Time Eligible ☐ Late Enrollee **(Statement of Health Required)** ☐ Change in Insurance Amount Requested ☐ Change in Enrollment Other Than Insurance Amount

SECTION TO BE COMPLETED BY THE EMPLOYEE

Please print clearly, sign and date this form. Return your completed form to your Employer's Personnel Office.

Name: Last First MI	Social Security Number	Date of Birth (Mo./Day/Yr.)

Home Address	Street	City	State	Zip

☐ Single ☐ Married | Number of Dependents (including spouse) __________ | ☐ Male ☐ Female

I am enrolling for all insurance indicated with an "X". I have received and read a copy of my employer's current announcement of the group plan.

	Employee	Spouse (Subject to State Limitations)	Dependent Child (Subject to State Limitations)	For insurance I am **declining**, I have circled the reason below. **(A)** Benefits Elsewhere **(B)** Cost **(C)** Other
Dental	☐	☐	☐	A B C ______________
Basic Life	☐	NA	NA	A B C ______________
Accidental Death & Dismemberment (AD&D)	☐	NA	NA	A B C ______________
Enhanced Optional / Dependent Life	☐ $__________	☐ $__________	☐ $__________	A B C ______________
Enhanced Optional / Dependent AD&D	☐	☐	☐	A B C ______________

☐ **I wish to decline any insurance not checked for which my dependents or I may be eligible.** If I request Life 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 (as defined on page 2). For Dental Insurance, a waiting period may be required for certain services before expenses will be payable.

Dental & Dependent Life/AD&D: List Dependents to be enrolled *(for additional space, please use a second Enrollment Form)*

	Last Name	First Name	MI	Date of Birth (MM/DD/YY)	Male/Female
Spouse					
Child					
Child					
Child					

For employees electing Enhanced Optional Life and Enhanced Dependent Life Insurance, please answer the following question

Have you or your dependent(s) (if applicable) been Hospitalized(as defined on page 2) 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

Beneficiary Designation for Employee Insurance: If you have elected Life Insurance, please complete this section. If multiple beneficiaries are designated, please use an additional enrollment form. I hereby name the following person as beneficiary for any MetLife benefit payment upon my death. The Dependent Life Insurance benefits are payable to the employee.

Primary Beneficiary Share %
Name ____________________ ______
Address ____________________
Date of Birth _________ Relationship to me __________

Contingent Beneficiary (if primary is deceased) Share %
Name ____________________ ______
Address ____________________
Date of Birth _________ Relationship to me __________

I RESERVE the right to change this designation at any time. Unless Designated otherwise, payments will be made in equal shares or all to the survivor.

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.

I declare that I am actively at work on the date of this enrollment form. **For Dental Insurance, I understand** that if I am not actively at work on the Effective Date, such Insurance will take effect on the date I return to active work. **For my Enhanced Optional Life Insurance, I understand** that I must be actively at work for at least 20 hours during the 7 calendar days preceding the effective date of this insurance for such insurance to take effect I understand that if I am not actively at work on the effective date of my Enhanced Optional Life Insurance, such insurance will take effect after I have been actively at work for at least 20 hours during the 7 calendar days. **For Enhanced Dependent Life Insurance, I understand that** on the date insurance is scheduled to take effect, my dependents must not be confined at home under a physician's care; receiving or applying for disability benefits from any source; or Hospitalized (as defined below). If my dependents do not meet this requirement on such date, insurance will take effect on the date my dependents are no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **For Enhanced Optional & Dependent Life Insurance, I also understand** that if on the Effective Date of my and my dependents Life Insurance I and my dependents have been Hospitalized during the 90-day period preceding the effective date, such insurance will not take effect until MetLife receives my and my dependents' evidence of good health Satisfactory to MetLife (as defined below).

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.

Satisfactory to MetLife means MetLife has discretionary authority to determine eligibility.

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

Benefit Increases Requested After Initial Enrollment Period

I understand that if I have not elected the maximum Life Insurance for which I or my dependent(s) are eligible, I or my dependent(s) may be required to submit evidence of good health Satisfactory to MetLife if I want to increase such insurance after my initial enrollment period.

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 Health Insurance (AD&D/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 (Mo./Day/Yr.)

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

Proposed Dependent age 18 or older Date (Mo./Day/Yr.)

Proposed Dependent age 18 or older | Date (Mo./Day/Yr.)