MetLife®
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FOR FOR

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print)			Group Report No.	Sub Division	Branch
Employer's Street Address	City		State	Zip Code	Employee Work Location
Date of Hire (Mo./Day/Yr.)	Employee Basic Annual Earnings (BAE) $	Employee's Occupation:		Coverage Effective Date (Mo./Day/Yr.):	
Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence		Hours Worked Per Week:		☐ Hourly Paid ☐ Salaried	☐ Full-Time ☐ Part-Time
☐ Original COBRA Effective Date (Mo./Day/Yr.)________					
Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Late Enrollee (**Statement of Health Required**) ☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount ☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) ________					

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City	State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-mail Address		Phone No. (include area code)	

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☒ Basic Life(Employer Paid)Class A, B and D - $10,000 Class C - $2,500

☒ Accidental Death & Dismemberment (AD&D) (Employer Paid)

Dependent Spouse/Domestic Partner Coverage

☐ Dependent Spouse/Domestic Partner Life* Class A & D - $4,000

For Domestic Partner coverage, you must complete and attach a Domestic Partner Declaration or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available. Check the applicable box:

☐ My Domestic Partner Declaration is attached.

☐ My Domestic Partner and I are registered as domestic partners or members of a civil union as stated above.

Dependent Child Coverage

☐ Dependent Child Life* Class A & D - $4,000

*Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse/Domestic Partner and Child), complete section below:

Number of dependents (including spouse/domestic partner)

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

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

Child(ren)	Name of School

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)

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DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, 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.

The employee **declares** that he or she is actively at work on the date of this enrollment form. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date. If Hospitalized during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of good health satisfactory to MetLife.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For Changes Requested After Initial Enrollment Period Expires

I understand that if life 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.

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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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 they have read and understand the statements and declarations made in this enrollment form.

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