

# 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	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Hours worked per week _____	Date of Hire(MM/DD/YY) _____	
Work Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Re-hire - Date: ___/___/___ <input type="checkbox"/> Layoff/Leave of Absence				
Employee Earnings \$ _____ Per <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year <input type="checkbox"/> Hour	<input type="checkbox"/> Original COBRA eff. Date: ___/___/___ No. of mos. ____			
Earnings include: <input type="checkbox"/> Bonus \$ _____ <input type="checkbox"/> Commission \$ _____	Dep. Soc. Sec. No. _____		Surviving Spouse Soc. Sec. No. _____	
Reason for Enrollment: <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required)				
Enrollment: <input type="checkbox"/> Change in Insurance Amount Requested <input type="checkbox"/> 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
<input type="checkbox"/> Single <input type="checkbox"/> Married	Number of Dependents (including spouse) _____		<input type="checkbox"/> Male <input type="checkbox"/> 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.				
	Subject to State Limitations		For insurance I am <b>declining</b> , I have circled the reason below. (A) Benefits Elsewhere (B) Cost (C) Other	
	Employee	Spouse	Dependent Child	
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A B C _____
Basic Life	<input type="checkbox"/>	NA	NA	A B C _____
Accidental Death & Dismemberment (AD&D)	<input type="checkbox"/>	NA	NA	A B C _____
Enhanced Optional / Dependent Life	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	A B C _____
Enhanced Optional / Dependent AD&D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A B C _____
Short Term Disability	<input type="checkbox"/>	NA	NA	A B C _____
Long Term Disability	<input type="checkbox"/>	NA	NA	A B C _____
<input type="checkbox"/> I wish to decline any insurance not checked for which my dependents or I may be eligible. 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 (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 %	Contingent Beneficiary (if primary is deceased)	Share %
Name _____	_____	Name _____	_____
Address _____	_____	Address _____	_____
Date of Birth _____ Relationship to me _____	_____	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 or Disability 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.

**I understand** that if I have not elected the maximum Disability Insurance for which I am eligible, I may be required to submit evidence of good health Satisfactory to MetLife if I want to increase such Disability

Insurance after my initial enrollment period.

**I also understand** that Disability Insurance will not take effect, or will be limited, until I receive notice that MetLife has approved the insurance increase.

**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/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 (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.)

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Proposed Dependent age 18 or older

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Date (Mo./Day/Yr.)