



Metropolitan Life Insurance Company, New York, NY

**BASIC LIFE & AD&D • ENROLLMENT • CHANGE FORM**

<b>GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)</b>				
Name of Group Customer/Employer	Group Customer #	Division	Class	Dept Code
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

<b>YOUR ENROLLMENT INFORMATION (To be Completed by the Employee in blue or black ink)</b>				
Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address (Street, City, State, Zip Code)			Date of Birth (MM/DD/YYYY)	
<input type="checkbox"/> Employee <input type="checkbox"/> Retiree	Job Title:	Basic Annual Earnings: \$	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Hours Worked Per Week:
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment    If due to a Qualifying Event, enter date (MM/DD/YYYY)				

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.  
 ► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

<b>Term Life and Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</b>	
<input type="checkbox"/> Basic Life <sup>1</sup> and AD&D (Core)	
<input type="checkbox"/> Basic Dependent Spouse <sup>2</sup> Life <sup>1,3</sup>	
<input type="checkbox"/> Basic Dependent Child Life <sup>3</sup>	

<b>Dependent Information</b>	
If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:	
Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)
_____	_____
	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)
_____	_____
_____	_____
_____	_____
_____	_____
	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Male <input type="checkbox"/> Female
	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.	

<sup>1</sup> 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. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.  
<sup>2</sup> Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.  
<sup>3</sup> Amounts will be subject to state limits, if applicable.

## BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL: 100%**

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):


Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL: 100%**

## DECLARATIONS AND SIGNATURE


By signing below, I acknowledge:

- I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
- I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
- I understand that, 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.
- I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for 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 understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
- I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
- I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
- I have read the applicable Fraud Warning(s) provided in this enrollment form.

	<div style="border-bottom: 1px solid black; width: 100%;"></div>		
	Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

## PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage (if applicable). This authorization applies to such coverage until I rescind it in writing.

	<div style="border-bottom: 1px solid black; width: 100%;"></div>		
	Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)