DO NOT STAPLE

TEAM KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

LIFE INSURANCE ENROLLMENT AND CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Commonwealth of Kentucky	**235782**	**235782**	**0001**	**0001**

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

Company Number	Company Name (Agency, Health Dept., School Board)	Organizational Unit Number	Cost Center Number
00571	Warren County Schools	10006616	9200100571

☐ **Termination**: Date Employment Ends _____ Date Life Insurance Terminates _____

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____

☐ **Reinstate Coverage**: Date Returned to Work _____ Date Insurance Effective _____

Reason: ☐ LWOP ☐ Military Leave ☐ Other_____

☐ **Transfer or Summer Transfer** To be completed by the NEW company

Prior Company Number:	New Company Number:
Last Day Worked at Prior Company:	Date Hired at New Company:
Coverage End Date at Prior Company:	Coverage Begin Date at New Company:

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female

Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)

Work Phone # / Home/Cell Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event 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 that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

► If you are enrolling after the initial enrollment period during mid-year elections, you must also complete a Statement of Health form.

Term Life Insurance

☒ Basic Life

☐ Supplemental/Optional Life

☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $150,000

Dependent Spouse Life and Dependent Child Life

- ☐ Option 1 – Dependent Spouse Life $10,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $5,000
- ☐ Option 2 – Dependent Spouse Life $20,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000
- ☐ Option 3 – Dependent Spouse Life $50,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000
- ☐ Option 4 – Dependent Spouse Life $10,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 5 – Dependent Spouse Life $20,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 6 – Dependent Spouse Life $50,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 7 – Dependent Spouse Life $0; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $5,000
- ☐ Option 8 – Dependent Spouse Life $0; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D ☐ Supplemental/Optional AD&D

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you areapplying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guiltyof a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent ofan insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an applicationcontaining any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offenseand may be subject to penalties under state law.

Kentucky: 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.

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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presentsfalse information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other personfiles an application for insurance or 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 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.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of aninsurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony andif found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claimcontaining a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

☐ Check if this is a Beneficiary Change

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)			Home 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:

1. 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.
2. 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 am performing all the usual and customary duties of the job on a full-time basis. 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.
3. 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.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.



Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)
IC/HRG Signature	Print Name	Date Signed (MM/DD/YYYY)
	Sherry Stratton	