



Metropolitan Life Insurance Company, New York, NY  
 Small Market Administration  
 P.O. Box 14593, Lexington, KY 40512-4593  
 Fax: 1-888-505-7446

**ENROLLMENT FORM FOR GROUP INSURANCE**  
**SECTION TO BE COMPLETED BY EMPLOYEE**

(PLEASE PRINT)

Name of Employee Last First Middle			Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Address Street			City State Zip Code	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Employee's E-mail Address			Phone No. (include area code)		
Name of Employer			Customer Number	Division	Class Dept Code
Employer's Street Address		City	State	Zip Code	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		Hours Worked Per Week	<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Annual <input type="checkbox"/> Monthly	Salary \$	
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____					
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire/First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____					
<b>COVERAGE REQUEST DATA:</b>					
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 for which I am or may become eligible, requested below.					
<b>I request the following coverage:</b>					
<b>Employee Coverage</b>					
<input type="checkbox"/> Life/Accidental Death & Dismemberment (AD&D): Amount Requested \$ _____					
<input type="checkbox"/> Short Term Disability (STD)					
<input type="checkbox"/> Dental					
<b>Dependent Spouse Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)</b>					
<input type="checkbox"/> Dependent Spouse Life* (*Amounts will be subject to state limits, if applicable.)					
<input type="checkbox"/> Dental					
<b>Dependent Child Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)</b>					
<input type="checkbox"/> Dependent Child Life* (*Amounts will be subject to state limits, if applicable.)					
<input type="checkbox"/> Dental					
<input type="checkbox"/> I wish to <b>DECLINE</b> any coverage not checked above for which I may be eligible. For Life, LTD and/or STD coverage, I understand that I will be required to submit evidence of my and/or my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired. For Dental and/or Dependent Dental coverage, a waiting period may be required before I can enroll. If I request Voluntary Short Term Disability after my initial enrollment period, I understand that I can become covered for no more than \$100 of Weekly Benefit by enrolling during the next enrollment period. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____					

**If applying for Dependent coverage (Spouse or Child), complete the following:**

Number of dependents (including spouse) \_\_\_

Name of Spouse (Last, First, MI)

Date of Birth

Sex (M/F)

Name(s) of Child(ren) (Last, First, MI)

Date of Birth

Sex (M/F)

Is child a full-time student?

Yes

Yes

Yes

Yes

**For employees electing Enhanced Optional Life (or Buy-Up) and Enhanced Dependent Life (or Buy-Up) Insurance, please answer the following question:**

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?

**Employee**

Yes  No

**Spouse**

Yes  No

**Child(ren)**

Yes  No

**If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."**

**Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility; intermediate care facility, or long term care facility, or receipt of the following treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

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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 and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

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 the Accelerated Benefits Option**

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. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

**For Changes Requested After Initial Enrollment Period Expires**

I **understand** that if life or disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability 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. I also **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

**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.

