



Metropolitan Life Insurance Company  
One Madison Avenue, New York, New York 10010-3690

**APPLICATION FOR GROUP INSURANCE**

The applicant named below is applying for a Group Policy to provide insurance for the persons specified below.

**APPLICANT DATA**

- 1. Full legal name of Applicant: \_\_\_\_\_ (the "Policyholder")
- 2. Street Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
(Do not use post office box address)

**POLICY EFFECTIVE DATE**

The Group Policy's effective date will be \_\_\_\_\_, subject to MetLife's acceptance of this application and the Applicant's payment of the Premium due on or before such date.

**POLICY SITUS**

The Group Policy will be issued for delivery in and governed by the laws of \_\_\_\_\_.

**COVERAGE DATA**

|   | <b>Employees / Members<br/>Only</b> | <b>Employees / Members<br/>and Dependents</b> |
|---|-------------------------------------|---|
| Basic Life (or Core)                                    | <input type="checkbox"/>            |   |
| Basic Life <b>with AD&amp;D</b> (or Core)               | <input type="checkbox"/>            |   |
| Enhanced Optional Life (or Buy Up)                      | <input type="checkbox"/>            | <input type="checkbox"/>                      |
| Enhanced Optional Life <b>with AD&amp;D</b> (or Buy Up) | <input type="checkbox"/>            | <input type="checkbox"/>                      |
| Dependent Life (or Buy Up)                              |                                     | <input type="checkbox"/>                      |
| Dependent Life <b>with AD&amp;D</b> (or Buy Up)         |                                     | <input type="checkbox"/>                      |
| Dental  | <input type="checkbox"/>            | <input type="checkbox"/>                      |
| Long Term Disability                                    | <input type="checkbox"/>            |   |
| Short Term Disability                                   | <input type="checkbox"/>            |   |

**PREMIUM DATA**

Premiums will be paid:  monthly  quarterly  annually  other: \_\_\_\_\_  
Attached is an advance payment of: \$ \_\_\_\_\_.

**AGREEMENT**

The Applicant signing below agrees to accept the terms and provisions of the Group Policy, including its Exhibits, amendments and endorsements, if any.

**Fraud Warning.** 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.

\_\_\_\_\_  
(Signature of Applicant's Legal Representative)

\_\_\_\_\_  
(Print Name and Title of Legal Representative)

Signed at: \_\_\_\_\_  
(City) (State)

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness)

\_\_\_\_\_  
(Print Name of Witness)

\_\_\_\_\_  
(Signature of Licensed Agent or Resident  
Agent as required by law)

\_\_\_\_\_  
(Agent's State License No.)

\_\_\_\_\_  
(Print Name of Agent)