



ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Division #	Class	Dept Code
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security #	<input type="checkbox"/> Male	<input type="checkbox"/> Single
Address (Street, City, State, Zip Code)		- -	<input type="checkbox"/> Female	<input type="checkbox"/> Married
Phone #	Email Address	Job Title:	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. I have received and read a copy of the Outline of Coverage or other disclosure document for the Specified Disease Insurance. In certain states, this coverage may be referred to as Critical Illness Insurance, Specified Disease Insurance, Limited Benefit Insurance or Limited Benefit Critical Illness Insurance.

Specified Disease Insurance

First select your option	Then select your level of coverage
<input type="checkbox"/> \$10,000	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse/Domestic Partner ¹ <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Spouse/Domestic Partner ¹ + Child(ren)

	Employee	Spouse/ Domestic Partner	Child(ren)
For all persons to be insured is there coverage in force that provides benefits for at least major medical, or at least basic hospital and basic medical?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you, your spouse/domestic partner or dependent children currently have coverage under, or currently have an application pending for, any other critical illness or specified disease policy? (If yes, please list who is covered and the conditions under the other policy(ies))	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (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

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

¹ Domestic Partner 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. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

GEF02-1 ADM
 (The form number above applies to residents of all states except as follows: Form number **GEF02-1 ADM** applies to residents of Oregon; **GEF09-1** applies to residents of Louisiana and Montana; and **GEF02-1 ADM** applies to residents of New Mexico, North Dakota and Utah)

SUBMISSION INSTRUCTIONS

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

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

Your Critical Illness certificate provides limited benefits. Read your certificate carefully.

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. 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. **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 treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
- 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.
- 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.

New York (only applies to Accident and Health Benefits): 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 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.

	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
	Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1

DEC

(The form number above applies to residents of all states except as follows: Form number GEF09-1 DEC applies to residents of Oregon;

GEF09-1 applies to residents of Louisiana and Montana; and

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DEC applies to residents of New Mexico, North Dakota and Utah)