MetLife®

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 #	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Employee's Address Street City State Zip Code		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Employee's E-mail Address	Phone No. (include area code)		
Name of Employer Town of Biscoe	Group Customer # TM05587573	Division	Class / Dept Code
Employer's Street Address	City / State	Zip Code	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	☐ Full-Time ☐ Part-Time	Employee's Occupation	Coverage Effective Date (Mo./Day/Yr.)
Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence		Hours Worked Per Week	☐ Hourly Paid ☐ Annual ☐ Monthly
☐ Original COBRA Effective Date (Mo./Day/Yr.)		Salary $	

Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Change in Enrollment
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____

COVERAGE REQUEST DATA:

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.

I request the following coverage:

Employee Coverage

☐ Dental
☐ Dental Dual Option (Select one option): ☐ Low Plan ☐ High Plan
☐ Voluntary Dental

Dependent Spouse Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐ Dental/Dental Dual Option/Voluntary Dental

Dependent Child Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐ Dental/Dental Dual Option/Voluntary Dental

☐ **I wish to DECLINE any coverage not checked above for which I may be eligible.** For Dental and/or Dependent Dental Coverage, a waiting period may be required before I and/or a dependent can be enrolled. 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	Is child a full-time student?
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes
		☐ M ☐ F	☐ Yes

Please Retain A Copy Of The Fully-Completed Form For Your Records And Return The Original To Your Employer

(Continued on Following Page)

A8000NW (02/09)

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief.

The employee **declares** that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **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.

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date Signed (Mo./Day/Yr.)