MetLife®
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR CITY OF TALLAHASSEE

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print) **City of Tallahassee**		Group Report No. **98014**	Sub Division	Branch
Employer's Street Address	City	State	Zip Code	Employee Work Location

Date of Hire (Mo./Day/Yr.)	Employee Base Annual Salary (BAS) $	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 ☐ Salaried	☐ Full-Time ☐ Part-Time

Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Late Enrollee **(Statement of Health Required)**
☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City	State Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-mail Address		Phone No. (include area code)	

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 which I am or may become eligible, requested below.

I request the following coverage:

☐ **Employee Coverage Optional Life**

☐ $30,000 ☐ $50,000 ☐ $80,000 ☐ $100,000 ☐ $130,000 ☐ $150,000 ☐ $180,000 ☐ $200,000 ☐ $230,000 ☐ $250,000

(**Note**: Amounts exceeding $150,000 require a Statement of Health Form.)

☐ Voluntary Accidental Death & Dismemberment (VAD&D) I understand my VAD&D benefit plan described in the announcement. I want to be covered under the group plan for which I am or may become eligible.

VAD&D Coverage Options: ☐ Employee Only ☐ Family Protection Plan Plus

VAD&D Scheduled Plan Design: You may elect benefit payments from $25,000 to $150,000 in $25,000 increments. Your total employee coverage cannot exceed $150,000. Coverage requested: $_____

Dependent Spouse Life Coverage

☐ Dependent Spouse Life* ☐ $15,000 ☐ $25,000 ☐ $40,000 ☐ $50,000 ☐ $65,000 ☐ $70,000 ☐ $95,0000 ☐ $100,000

Dependent Child Life Coverage

☐ Dependent Child Life* ☐ $5,000

*Amounts will be subject to state limits, if applicable.(Note: Amounts exceeding $50,000 require a Statement of Health Form.)

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)

Name (Last, First, MI)	Date of Birth	Sex (M/F)
Spouse:		
Child(ren):		

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School

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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. 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. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date.

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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

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 that 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 coverage is not elected, or if the maximum coverage is not elected, evidence of good health 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.

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 and Oregon: 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.

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

In any other case, read the following warning.

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 is a crime and subjects such person to criminal and civil penalties.

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BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)			
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.			
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)

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

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

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature _____ Print Name _____ Date (Mo./Day/Yr.) _____

Other Signature _____ Print Name _____ Date (Mo./Day/Yr.) _____