

Please print clearly and be sure to sign and date this form. Return your completed form to your employer's Personnel Office.

**Employee Information**

Employee's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Maiden Name) \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex  Male  Female  
 Married  Divorced  Single  Widowed  Yes  No  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Marital Status \_\_\_\_\_ No. of Dependents \_\_\_\_\_ Other Insurance \_\_\_\_\_  
 If yes, name of Carrier \_\_\_\_\_

**Employment Information**

Employer Name \_\_\_\_\_ Group # \_\_\_\_\_ Date of Hire \_\_\_\_\_ Occupation/Job Title \_\_\_\_\_ \$ \_\_\_\_\_ per  Year  Week  Month  
 Current Earnings \_\_\_\_\_  
 Active  Disabled  Layoff/Leave of Absence  New Hire  Rehire Date: \_\_\_\_\_  Hourly  Salaried  
 Worksite Zip Code \_\_\_\_\_ Work Status \_\_\_\_\_ Hours Worked Per Week \_\_\_\_\_

**Type of Coverage**

**Employee Coverage(s) Requested**  Life/AD&D  Dental **Dependent Coverage(s) Requested**  
 Short Term Disability  Long Term Disability  Dependent Life  Dental

- 1. I have no dependents, so I am enrolling for myself only.
- 2. I wish to enroll for all available coverages for myself and my dependents.
- 3. I wish to enroll for all available coverages for myself, but I do not want coverage for my dependents.
- 4. I wish to decline all contributory coverages for myself for which I may be eligible.
- 5. I wish to decline the following coverage(s) for which I would have to make a contribution: \_\_\_\_\_

**General Information**

**Instructions to employee:** Complete the following for you and any dependents you wish to cover. (If more space is needed, please use additional Enrollment Forms.)

Names of Persons Applying for Coverage (Include Last Name if Different from Employee)	Sex	Date of Birth	State/Country of Birth	Height	Weight	Relationship to Employee	Student Full-Time?	Disabled?
Employee						Self		
Spouse						Spouse		
Child								
Child								
Child								
Child								
Child								

## Beneficiary Designation

If you have elected Life Insurance, please complete this section. If multiple beneficiaries are designated, please use additional enrollment forms. I hereby name the following person as beneficiary for any MetLife benefit payment upon my death.

### Primary Beneficiary

Name \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Relationship to me \_\_\_\_\_

### Contingent Beneficiary (if primary is deceased)

Name \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Relationship to me \_\_\_\_\_

## Health Questions – Not required for person applying for dental coverage only.

Omitted information will cause delays. Please provide details for "yes" answers below or on a separate sheet.

1. Has any application for life or health insurance on account of the proposed insured ever been declined, postponed, or issued other than as applied for, or withdrawn, or have you failed to receive notice of action on such application? If "Yes," give details including dates.

Yes  No

2. If the proposed insured is a female, is she now pregnant?

Yes  No

3. Does the proposed insured have any deformity, loss or impairment of limb, or any impairment of sight or hearing?

Yes  No

4. Has the proposed insured ever been advised by a physician or other practitioner to have an operation that has not been performed?

Yes  No

5. Has the proposed insured ever been advised by a physician or other practitioner to modify or restrict his/her eating, drinking, or living habits?

Yes  No

6. Has the proposed insured ever received treatment, attention or advice from any physician or other practitioner for, or been told by any physician or other practitioner that he/she had:

**Yes No**

(a) High blood pressure, chest pain or heart trouble?

(b) Asthma, bronchitis, tuberculosis or other disease of the lungs?

(c) Gallstones, ulcers or any disease of the liver?

(d) Epilepsy, paralysis, dizziness or any mental or nervous disorder?

(e) Cancer or other tumor?

(f) Arthritis or rheumatic fever?

(g) Diabetes; disease of the kidneys?

(h) Anemia, leukemia or other disease of the blood?

7. During the past two years, has the proposed insured had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, swollen glands, patches in mouth, visual disturbance, or recurring diarrhea, fever or infection?

Yes  No

8. During the past five years, has the proposed insured had any diseases, ailments, or injuries not revealed elsewhere on this statement for which there was treatment, examination, or advice by or under the direction of a physician or other practitioner, or at a clinic, hospital, dispensary, or sanitarium?

Yes  No

Question Number	Person	Disorder, Reason or Condition	Dates of Treatment		Result	Names, Addresses, and Telephone Number of Physicians Consulted

The name and address of the regular attending physician for each person with dates and reasons consulted should be shown above.

## Certification Authorization and Signature

**Declaration by proposed insured or by the employee, if the proposed insured is under 14** – I declare that the information given above is true and complete to the best of my knowledge. If coverage is provided on the basis of this information and any of my statements or answers are incomplete, incorrect, or untrue, neither MetLife nor the employer shall have any liability under the coverage provided.

**Authorization by the proposed insured or by the proposed insured's parent or guardian, if the proposed insured is a minor** –

For underwriting and claim purposes, I **authorize**: any physician or other medical practitioner, hospital, clinic, other medical related facility, health plan, insurer, employers and group policyholders, Medical Information Bureau, contractholders and benefit plan administrators:

To disclose to Metropolitan Life Insurance Company ("MetLife") or its designated representative: All medical and insurance information about the person proposed for coverage, including medical history, diagnosis, prognosis and treatment of any physical or mental condition. This includes, but is not limited to, disclosure of medical care or surgery; psychiatric or psychological care or examinations; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. I understand that this authorization includes my consent to disclose medical information that relates to mental illness, HIV, AIDS, HIV-related illness and sexually transmitted diseases or other serious communicable diseases, but only in accordance with any law or regulation that applies to any such disclosure of this information about the person proposed for insurance. Any fees will be paid by me.

**MetLife may use and re-disclose any medical information in its possession as indicated in the Consumer Privacy Notice, a copy of which has been given to me.**

I understand that I may have a right to receive a copy of this authorization upon request and that I may revoke this authorization at any time. If I do not revoke it, it will be valid for 24 months from the date I sign it. A photocopy of this authorization is as valid as the original form.

Notice to residents of New York, with respect to coverages other than life insurance:

**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 concerning 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 \$5,000 and the stated value for each such violation.**

Notice to residents of 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.**

Notice to residents of 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.**

Notice to residents of Virginia:

**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.**

Notice to jurisdictions not listed above:

**Any person who knowingly and with intent to defraud any insurance company or other person files 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.**

The employee must sign in all cases. The person for whom coverage is being requested must also sign if not under age 14.

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Signed

(Employee)

Date

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Signed

(Person for whom coverage is being requested if not under age 14 and if other than employee)

Date

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Metropolitan Life Insurance Company