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 WEST VALLEY-MISSION COMMUNITY COLLEGE DISTRICT	Group Customer # 5589969	Division	Class	Dept Code

Employer's Street Address 1400 FRUITVALE AVE.	City SARATOGA	State CA	Zip Code 95070	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	Salary $

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.) _____

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 (please check Family or Employee Only Enhanced Optional Life AD&D)

☐ Enhanced Optional AD&D: Family _____ Employee Only ____ Coverage Requested $ (Guarantee Issue: $250,000)

☐ Enhanced Optional Life: Coverage Requested $ _____ (Guarantee Issue (GI) = $250,000)

Dependent Spouse Coverage

☐

☐ Enhanced Dependent Spouse Life: (GI = $20,000) Coverage Requested $_____

Dependent Child Coverage

☐

☐ Enhanced Dependent Child Life: Coverage Requested $_____ (Guarantee Issue: $10,000)

☐ **I wish to DECLINE any coverage not checked above for which I may be eligible.** For Life coverage, I understand that I will be required to submit evidence of my and/or my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other):

_____

(Continued on Following Page)

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

For employees electing Supplemental/Enhanced Optional Life (or Buy-Up) and Enhanced Dependent Life (or Buy-Up) Insurance, please answer the following question:

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?	**Employee**	**Spouse**	**Child(ren)**
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

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.

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DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, 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 and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

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 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 insurability 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, 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.

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. 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)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	**100%**

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	**100%**

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.

Sign Here

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