MetLife

Metropolitan Life Insurance Company, New York, NY 10166

GROUP ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee/Certificateholder)

Name (First, Middle, Last)	Policy #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Email Address	Phone #	

☐ Change in Enrollment If change is due to a Qualifying Event, enter event date (MM/DD/YYYY) _____

Qualifying Event: _____ If you are making a change due to a Qualifying Event, a Statement of Health form may be required.

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. I understand the amounts of insurance I request must comply with and are limited by the plan described in my enrollment materials.

Group Universal Life (GUL) Insurance

Note: A reduction in coverage may result in an irreversible Modified Endowment Contract (MEC) status and unfavorable tax treatment of withdrawals and loans, depending on circumstances. If you are planning to reduce your GUL coverage and do not want your certificate to become a MEC, please call 1-800-756-0124 to find out whether this will result in unfavorable tax consequences.

☐ GUL [1]

Change my total GUL[1] coverage amount to: $_____ Enter an amount up to the maximum described in your enrollment materials.

Monthly Contribution to the GUL Cash Fund: ☐ $0 ☐ $10 ☐ $15 ☐ $25 ☐ Other: _____

Term Life Insurance

☐ Dependent Spouse/Colorado Statutory Designated Beneficiary/Civil Union Partner/Domestic Partner [2] Term Life Rider[1,3]

Enter an amount up to the maximum described in your enrollment materials. $_____

☐ Dependent Child Term Life Rider [3]

Enter an amount up to the maximum described in your enrollment materials. $_____

[1] 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. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] 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. If your plan includes coverage for non-registered domestic partners, Domestic Partner 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. For Colorado sitused cases, Dependent Spouse includes your Colorado Statutory Designated Beneficiary.

[3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM
(The form number above applies to all situs states and residents of Connecticut, North Dakota, and Utah except as follows: Form number **GEF09-1** *applies to all situs states of Kentucky, Louisiana, and New Mexico and residents Montana*;
GEF02-1a
ADM *applies to situs state of Maryland*;
GEF02-1A
ADM *applies to situs state of New Hampshire*;
GEF02-1 ADM *applies to situs state of Oregon*;
GEF13-1
ADM *applies to situs state of Virginia)*

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Underwriting, P.O. Box 4377, Scranton, PA 18505-6377.
Fax: 570-558-8643 Email: MetLife_Underwriting@trustflowds.com
If you have any questions, call a MetLife Customer Relations Specialist at 1-800-756-0124.

Dependent Information

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

Name of your Spouse/Colorado Statutory Designated Beneficiary Civil Union Partner/Domestic Partner (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Social Security # | ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Full Time Student [1]?

		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ Female
		☐ Yes ☐ No	☐ Male ☐ 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.

Smoking Status Information

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 5 years? Employee/Certificateholder ☐ Yes ☐ No Spouse/Domestic Partner ☐ Yes ☐ No

If you are changing smoking status Status is changing from: ☐ Smoker to Non-Smoker ☐ Non-Smoker to Smoker Change is for: ☐ Employee/Certificateholder ☐ Spouse/Domestic Partner

[1] Full Time Student means your dependent child, age 18 or older, enrolled as a full-time student in an accredited college, university, secondary school, or a vocational or trade school. Age limits will be subject to state limits, as applicable.

GEF02-1
ADM
(The form number above applies to all situs states and residents of Connecticut, North Dakota, and Utah except as follows: Form number **GEF09-1** *applies to all situs states of Kentucky, Louisiana, and New Mexico and residents Montana*;
GEF02-1a
ADM *applies to situs state of Maryland*;
GEF02-1A
ADM *applies to situs state of New Hampshire*;
GEF02-1 ADM *applies to situs state of Oregon*;
GEF13-1
ADM *applies to situs state of Virginia)*

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: 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.

Maine, Tennessee 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

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

Oklahoma: WARNING: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

Pennsylvania and all other states: 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 subjects such person to criminal and civil penalties.

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

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. 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 understand that this information will be used by MetLife to determine insurability.
2. **For group billing customers only:** 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. For Idaho situs only: this does not apply to replacement contracts.
3. 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.
4. I understand that if I did not enroll for life coverage during the initial enrollment period, or if I did not enroll for the maximum amount of coverage for which I was eligible, evidence of insurability satisfactory to MetLife may be required to enroll for 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.
5. **For group billing customers only:** 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.
6. For Massachusetts situs only: I have read the REQUIRED DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS provided in this enrollment form.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

For New York situs only: New York (only applies to Accident and Health Insurance): 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.

Sign Here

Signature of Employee/Certificateholder

Print Name | Date Signed (MM/DD/YYYY)

Sign Here

Signature of owner if a person other than the Employee/Certificateholder

Print Name | Date Signed (MM/DD/YYYY)

Sign Here

Signature of Trustee #1* if owner is a Trust

Print Name | Date Signed (MM/DD/YYYY)

Sign Here

Signature of Trustee #2* if owner is a Trust

Print Name | Date Signed (MM/DD/YYYY)

*All trustees must sign.

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

GEF09-1
DEC
(The form number above applies to all situs states and residents of Connecticut, North Dakota, and Utah except as follows: Form number **GEF09-1** *applies to all situs states of Kentucky, Louisiana, and New Mexico and residents of Montana*;
GEF09-1 DEC *applies to situs state of Oregon*;
GEF09-1A
DEC *applies to situs state of New Hampshire)*