

Enrollment Form for Group Insurance

Metropolitan Life Insurance Company

SBC Administration
P.O. Box 14593, Lexington, KY 40512-4593



| | | | | |
|--|-------------------------------|------------------------|-----------------|--------------|
| <i>Employee Name (Last, First, Middle)</i> | <i>Social Security Number</i> | <i>Customer Number</i> | <i>Division</i> | <i>Class</i> |
|--|-------------------------------|------------------------|-----------------|--------------|

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|--------------------------|-------------|--------------|------------|------------------|----------------------|--|
| <i>Your Home Address</i> | <i>City</i> | <i>State</i> | <i>ZIP</i> | <i>Sex (M/F)</i> | <i>Date of Birth</i> | <i>Marital Status</i> <input type="checkbox"/> <i>Single</i> <input type="checkbox"/> <i>Married</i> |
|--------------------------|-------------|--------------|------------|------------------|----------------------|--|

| | | | | |
|------------------------|----------------------|------------------|------------------------------|--|
| <i>Your Occupation</i> | <i>Employer Name</i> | <i>Hire Date</i> | <i>Hours Worked Per Week</i> | <i>Salary:</i> \$ <input type="checkbox"/> <i>Annual</i> <input type="checkbox"/> <i>Monthly</i> <input type="checkbox"/> <i>Hourly</i> |
|------------------------|----------------------|------------------|------------------------------|--|

Reason for Enrollment:

First Time Eligible Late Enrollee
 Change in Insurance Amount Requested Change in Enrollment Other Than Insurance Amount

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|-------------------------------|----------------------|------------------|---------------------|-------|-------|-------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------------------|-----------------------|-------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <p>Coverage Requested:</p> <p>Employee Coverage <input type="checkbox"/> Dental</p> <p>Dependent Spouse Coverage <input type="checkbox"/> Dental</p> <p>Dependent Child Coverage <input type="checkbox"/> Dental</p> | <p>If applying for Dependent Coverage (Spouse and Child), complete section below: <i>Number of dependents (including spouse)</i></p> <table border="0"> <tr> <td><i>Name (Last, First, MI)</i></td> <td><i>Date of Birth</i></td> <td><i>Sex (M/F)</i></td> </tr> <tr> <td><i>Spouse</i> _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><i>Child(ren)</i> _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <p>If dependent children are full-time students in college, vocational or trade school, please complete the following:</p> <table border="0"> <tr> <td><i>Child(ren)</i></td> <td><i>Name of School</i></td> <td><i># of Hours</i></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> | <i>Name (Last, First, MI)</i> | <i>Date of Birth</i> | <i>Sex (M/F)</i> | <i>Spouse</i> _____ | _____ | _____ | <i>Child(ren)</i> _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | <i>Child(ren)</i> | <i>Name of School</i> | <i># of Hours</i> | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
| <i>Name (Last, First, MI)</i> | <i>Date of Birth</i> | <i>Sex (M/F)</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Spouse</i> _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Child(ren)</i> _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <i>Child(ren)</i> | <i>Name of School</i> | <i># of Hours</i> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | | | | | | | | | | | | | | | | |

To decline coverage, complete this section:

I understand that I have been given the opportunity to participate in the group insurance plan offered by my Employer. I am refusing the coverage(s) indicated at the right for which I am required to contribute. For Dental Insurance, a waiting period may be required for certain services before expenses will be payable.

Dental

Employee Spouse Child

Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other):

DECLARATION SECTION -- TO BE COMPLETED BY THE EMPLOYEE

The Employee 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 understands that this information will be used by MetLife to determine insurability.

For the Accelerated Benefits Option

I understand that my 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. I also understand that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

New York [only applies to Accident and Health Insurance (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 an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and 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.

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.

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

For Payroll Deduction Authorization by the Employee

I authorize my Employer to deduct the required contributions from my pay for the insurance requested in this enrollment form. This authorization applies to such insurance until I rescind it in writing.

Employee Signature (The employee must sign in all cases.)

Date (Month/Day/Year)

Michigan Residents ONLY – Sign Below if Employee is enrolling for Dependent insurance on Page 1

Proposed Dependent age 18 or older

Date (Month/Day/Year)

Proposed Dependent age 18 or older

Date (Month/Day/Year)