

**ENROLLMENT • CHANGE FORM**

<b>GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)</b>				
Name of Group Customer/Employer State of California	Group Customer # 74503	Report #	Sub Code	Branch

<b>YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)</b>				
Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (Street, City, State, Zip Code)			Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	Basic Annual Earnings \$	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment	

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.  
 ► You must complete the Health Information section of this form for all amounts you are requesting.

<b>Term Life Insurance and Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</b>	
<input type="checkbox"/> Supplemental/Optional Life <sup>1</sup> /AD&D Enter a multiple of \$10,000 up to the lesser of 8x your Basic Annual Earnings or a maximum \$750,000. Coverage requested \$ _____ Note: A minimum coverage of \$20,000 is required to enroll in Dependent Spouse and/or Dependent Child Life.	
<input type="checkbox"/> Dependent Spouse <sup>2</sup> /Child Life <sup>3</sup> <input type="checkbox"/> \$7,500/\$7,500 <input type="checkbox"/> \$15,000/\$7,500 <input type="checkbox"/> \$25,000/\$7,500 <input type="checkbox"/> \$50,000/\$7,500	

<b>Dependent Information</b>	
If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:	
Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY) <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____ <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____ <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____ <input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____ <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.	

<sup>1</sup> 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.  
<sup>2</sup> Spouse 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.  
<sup>3</sup> Amounts will be subject to state limits, if applicable.

**GEF02-1 ADM**  
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; **GEF02-1 ADM** applies to residents of Connecticut, North Dakota, and Utah)

**SUBMISSION INSTRUCTIONS**  
 After completion, make a copy for your records and return the original to  
 MetLife Recordkeeping Center, P.O. Box 14402, Lexington, KY 40512-4402

## HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your height \_\_\_\_ feet \_\_\_\_ inches      Spouse height \_\_\_\_ feet \_\_\_\_ inches  
 Your weight \_\_\_\_ pounds                  Spouse weight \_\_\_\_ pounds

	Employee	Spouse	Child(ren)
1. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you now receiving or applying for any disability benefits, including workers' compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been <b>Hospitalized</b> as defined below (not including well-baby delivery) in the past 90 days?  <b>Hospitalized</b> 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 treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. <b>For residents of all states except CT, please answer the following question:</b> Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>For CT residents, please answer the following question:</b> To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:			
a. cardiac or cardiovascular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. stroke or circulatory disorder (such as peripheral artery disease)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer, Hodgkin's disease, lymphoma or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. asthma, COPD, emphysema or other lung disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

**GEF09-1a**

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

**GEF09-1**

**HEA** applies to residents of Connecticut, North Dakota, and Utah)

## 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.

**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 to the extent required by applicable law.

**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.

### GEF09-1a

*(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;*

### GEF09-1

*FW applies to residents of Connecticut, North Dakota, and Utah)*



### BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

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

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

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

**GEF09-1a**

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**GEF09-1**

*DEC applies to residents of Connecticut, North Dakota, and Utah)*

## DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. 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.
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 do not enroll for life coverage or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.



Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

## PAYMENT AUTHORIZATION

By signing below, 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.



Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

### GEF09-1a

*(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;*

### GEF09-1

*DEC applies to residents of Connecticut, North Dakota, and Utah)*

Some services in connection with your coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.



## Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

### Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

### Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

### Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

### How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

### Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

## Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

## HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at [www.MetLife.com](http://www.MetLife.com). For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

## Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

## Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

**Send privacy questions to:**

MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company**  
**Metropolitan Tower Life Insurance Company**  
**SafeGuard Health Plans, Inc.**  
**Delaware American Life Insurance Company**

**MetLife Health Plans, Inc.**  
**General American Life Insurance Company**  
**SafeHealth Life Insurance Company**