LIFE INSURANCE
ENROLLMENT FORM FOR GROUP INSURANCE
SECTION TO BE COMPLETED BY EMPLOYEE
(PLEASE PRINT)

Metropolitan Life Insurance Company, New York, NY
Small Market Medical Underwriting
P.O. Box 14593, Lexington, KY 40512-4593
Fax: 1-888-505-7446

Optional Life Only – Guarantee Issue Limit: $150,000

Name of Employee Last First Middle	Social Security No.	Date of Birth (M.o/Day/Yr.)	☐ Male ☒ Female		
Employee's Address Street City State Zip Code		Marital Status	☐ Single ☐ Widowed	☐ Married ☐ Divorced	
Employer's Email Address	Phone No. (include area code)				
Name of Employer	Customer Number	Division	Class	Dept. Code	
Employer's Street Address	City / State	Zip Code	Employee's Work Location		
Date of Hire (Mo./Day/Yr.)	☐ Full-Time ☐ Part-Time	Employee's Occupation	Coverage Effective Date		
Work Status ☐ New Hire ☐ Rehire ☐ Active ☐ On Layoff/Leave of Absence ☐ Retired ☐ Disabled		Hours Worked Per Week	☐ Hourly Paid ☐ Annual ☐ Monthly	Salary $	

☐ Original COBRA Effective Date (Mo./Day/Yr.) _____

Reason for Enrollment:
☐ New Coverage
☐ Change in Coverage Amount Requested
☐ Family Status Change (not applicable to new enrollments)
☐ New Hire First Time Eligible
☐ Change in Enrollment Other Than Coverage Amount
☐ Late Enrollee (Statement of Healthcare Required)
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

☐ Basic Life/Accidental Death & Dismemberment (AD&D) (or Core): Coverage Requested: $_____

☐ Enhanced Optional Life (or Buy-Up): Coverage Requested: $_____ (Not to exceed 5x Basic Annual Earnings) Short Term Disability (STD)

☐ Voluntary Short Term Disability: Coverage Requested: $_____ (Sold in increments of $50)

☐ Long Term Disability (LTD)

Dependent Spouse Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐ Dependent Spouse* (*Amounts will be subject to state limits, if applicable.)

☐ Enhanced Dependent Spouse Life (or Buy-Up):* Coverage Requested $_____ (Not to exceed 50% of Employee amount)

Dependent Child Coverage (**Note**: Dependent coverage is provided under the same plan the employee has chosen.)

☐Dependent Child Life* (*Amounts will be subject to state limits, if applicable.)

☐ Enhanced Dependent Child Life (or Buy-Up):* Coverage Requested $_____

☐ **I wish to DECLINE any coverage not checked above for which I may be eligible.** For Life, LTD and/or STD 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. For Dental and/or Dependent Dental coverage, a waiting period may be required before I can enroll. If I request Voluntary Short Term Disability after my initial enrollment period, I understand that I can become covered for no more than $100 of Weekly Benefit by enrolling during the next enrollment period. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

(Continued on Following Page)

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New Rochelle, NY • Santa Ana, CA

If applying for Dependent coverage (Spouse and Child), complete section below:			
Number of dependents (including spouse)			
Name of Spouse (Last, First, MI)	Date of Birth	Sex (M/F)	
Name of Child(ren) (Last, First, MI)	Date of Birth	Sex (M/F)	**Is child a full-time student?**
			☐ **Yes**
			☐ **Yes**
			☐ **Yes**
			☐ **Yes**

For employees electing 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. This does not apply to replacement contracts.

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.

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 or disability 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. I also **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

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.

(Continued on Following Page)

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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. Unless designated otherwise, payments will be made in equal shares or all to the survivor. 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)

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)**

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

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

Proposed Insured(s) if other than employee and at least 18 years of age:

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

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SECTION TO BE COMPLETED BY EMPLOYER (PLEASE PRINT CLEARLY)

Life Health Statement

Optional Life - Over Guarantee Issue

Employer Name	Customer Number	Reporting Location Number	
Employer's Street Address	City	State	Zip

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete)	First	Middle	Last	Employee Social Security Number (Must Complete)
Daytime Phone Number		Date of Full-Time Hire (Mo./Day/Yr.)	Work Status: ☐ Active ☐ Retired ☐ Disabled	Employee's Annual Salary

Insurance for ☐ Employee ☐ Spouse ☐ Child	Proposed Insured Name First MI Last	☐ Male ☐ Female	Date of Birth (Mo./Day/Yr.)

Mailing Address	City	State	Zip Code

Business Phone Number	Home Phone Number	E-mail Address	State of Birth	Country of Birth

Total Insurance Requested (To be completed for each Applicant)

☐ Basic Life (or Core) $_____	☐ Optional Life (or Buy-Up) $_____	☐ Short Term Disability $_____
☐ Dependent Life (or Buy-Up) $_____	☐ Long Term Disability $_____	

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ADM

Medical Information – Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

	YES	NO
1. Height___feet___inches Weight___lbs		
2. Are you now: a. Pregnant? b. Taking prescribed medications or on a prescribed diet? If "yes," list: _____ c. Receiving or applying for any disability benefits including workers' compensation?	☐ ☐ ☐	☐ ☐ ☐
3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) _____	☐	☐

5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	YES	NO		YES	NO
a. Chest pain or heart trouble?	☐	☐	h. Colitis, Crohn's or any intestinal disorder?	☐	☐
b. High blood pressure, stroke or circulatory disorder?	☐	☐	i. Epilepsy, paralysis or dizziness?	☐	☐
c. Cancer or tumors?	☐	☐	j. Mental or nervous disorder?	☐	☐
d. Anemia, leukemia or other blood disorder?	☐	☐	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	☐	☐
e. Diabetes? Insulin treated?	☐	☐	l. Arthritis, carpal tunnel, or any muscle weakness?	☐	☐
f. Asthma, tuberculosis, pneumonia, or other lung disease?	☐	☐	m. Kidney or urinary tract disorder?		
g. Ulcers, stomach or liver disorder?			n. Thyroid or other gland disorder?		
			o. Back, neck or spinal disorder?		

6. have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?

Personal Physician:	Date and reason for last visit:
Address:	Phone Number:

Give full details for "Yes" answers on the next page.

Make A Copy for Your Records & FAX or MAIL Completed Forms to Small Market Medical Underwriting, 1-888-505-7446, MetLife, PO Box 14593, Lexington, KY 40512-4593

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Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Clinic or Hospital and Complete Address, Including Zip Code

GEF02-1 MQ

Declaration – I have read this Statement of Health and declare that all information given above 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.

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(Employee must always sign) **Signed**		**Date**	
(Proposed Insured if other than Employee and at least 18 years of age) **Signed**		**Date**	

SM-SOH/NW
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Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- Personal information and data about the proposed insured;
- Medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
- Information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- Information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- Information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire in 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained this authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke this authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife received the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

Signature of Proposed Insured or Signature & Relationship of Personal Representative	Print Name of Proposed Insured	Date Signed (Mo./Day/Yr.)
To view the Privacy Notice for MetLife's Optional Life Health Statement: https://www.abelhr.com/metlife-optional-life-health-statement-privacy-notice/		

*If a child proposed for insurance is age 18 or over, the child must sign this authorization. If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A personal representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

GEF02-1a DEC

AUTH-NW

ENROLLMENT APPLICATION
PRIVACY NOTICE

Metropolitan Life Insurance Company, New York, NY
Small Market Medical Underwriting
P.O. Box 14593, Lexington, KY 40512-4593
Fax: 1-888-505-7446

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of these companies:

Metropolitan Life Insurance Company **Paragon Life Insurance Company**

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.
What we need to know includes address, age and other basic information. But depending on the type of product or insurance, we may need more information. This may include information about your finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies. Our affiliates currently include car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:
• Ask for a medical exam

• 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 your finances, employment, hobbies, mode of living, work history, and driving record.

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.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: We take steps we consider reasonable to make sure that what we know about you is treated confidentially. For example, our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have about you.

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How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose. We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If the law allows us to do so, we may disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you are writing about.

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