


Group Critical Illness Insurance Enrollment Form
For — Group Report No.

Employee Information						
Name (print)	First	Middle	Last	E-mail Address	Date of Birth (Mo./Day/Yr.)	
Address	Street	City		State	Zip Code	Social Security/Employee ID Number

If requesting Dependent coverage (Spouse and Child), complete section below:

	Name (Last, First, MI)	Date of Birth	Sex (M/F)	Social Security No.
Spouse:	_____	_____	_____	_____
Child(ren):	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____


COVERAGE REQUEST:
I have received and read a copy of the outline of coverage for Initial Coverage. I would like to receive the Initial Coverage for the benefit for myself, _____ benefit for my Spouse (if shown above), and _____ benefit for each of my Dependent Child(ren) (if shown above). I understand that no person will be covered until they are accepted for coverage by MetLife. I also understand that my Spouse and Dependent Child(ren) are not eligible for coverage if I am not approved for coverage.

 1. Do all persons to be insured have medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses?


Employee	Spouse	Child(ren)
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

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MEDICAL INFORMATION:
Please complete all questions below. Omitted information will cause delays. If more space is needed for full details, attach a separate sheet, sign and date it. "You" and "Your" refers to the person for whom insurance is requested.

 2. Have you EVER had any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; or (vi) an organ transplant (or been on a list for an organ transplant)?

Employee	Spouse	Child(ren)
<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. Are you actively at work performing all of the usual and customary duties of your job at the employer's place of business or an alternative place approved by the employer?

Employee
 YES NO

DECLARATION SECTION

The employee **declares** that he or she is actively at work on the date of this enrollment form. In addition if the employee is not actively at work on the scheduled Effective Date of the insurance requested, such insurance will not take effect until the employee returns to active work.

The employee declares that no person proposed for coverage is covered by any Title XIX program (Medicaid or any similarly named program).

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.

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. It is also unlawful for any insurance company or agent of an insurance company to knowingly provide 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 respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

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

Florida: Any person who knowingly and with the 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.

Kansas, Massachusetts, 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 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.

New York: 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.

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.

In any other case, read the following warning:

Any person who knowingly and with intent to defraud any insurance company or any 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.

Signature(s): The employee must sign in all cases. Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his or her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability. 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 (Mo./Day/Yr.)



Spouse Signature

Print Name

Date (Mo./Day/Yr.)

PLEASE RETAIN A COPY OF THE FULLY COMPLETED FORM FOR YOUR RECORDS; RETURN ORIGINAL TO:

IF YOU HAVE ANY QUESTIONS, CALL METLIFE AT 1 800 GET-MET 8 (1-800-438-6388)