MetLife®

METLIFE NON-CONTRIBUTORY BASIC LIFE & DEPENDENT LIFE ENROLLMENT FORM

Please print clearly and be sure to sign and date this form. Return your completed form to your employer's office.

Your Name: _____
(Last) (First) (Middle Initial)

Home Address: _____
Street City State Zip

Social Security Number: _____ **Date of Birth:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: (___) _____ **Work Phone:** (___) _____

Name of Employer: _____

Occupation: _____

Location of Employment: _____

Basic Life Coverage:
☐ I **want** to be covered under the group plan benefits for which I am eligible.

☐ I **DO NOT** want to be covered for the group plan benefits for which I am eligible. I understand that I will have to submit evidence of good health satisfactory to MetLife if I want this coverage at a later date.

Dependent Life Coverage:
☐ I **want** Dependent Life Insurance coverage for my:
☐ Spouse Only ☐ Child(ren) Only ☐ Spouse and Child(ren)

☐ I **DO NOT** want Dependent Life Insurance. I understand that my dependents will have to submit evidence of good health satisfactory to MetLife if they want this coverage at a later date.

Spouse's Name: _____ **Date of Birth:** _____
Name of Child(ren): _____ **Date of Birth:** _____
_____ **Date of Birth:** _____
_____ **Date of Birth:** _____

NOTE: ALL LATE ENROLLEES MUST COMPLETE A FULL STATEMENT OF HEALTH FORM (G11421-S).

Designation of Beneficiary (Dependent Life Benefits are Payable to the Employee Only)

☐ **I Designate as my Beneficiary** ☐ **My Designation of Beneficiary is on a separate form**

Name _____

Address _____

Date of Birth _____ Relationship to Employee _____

If the Beneficiary dies before me, I designate as contingent beneficiary:

Name _____

Address _____

Date of Birth _____ Relationship to Employee _____

- If there is more than one beneficiary, or more than one contingent beneficiary, they will share the death benefits equally, or all will be paid to the survivor.
- I RESERVE the right to change this designation at any time.

I certify that the information supplied above is true and that I am actively at work on the date of my enrollment.

_____ _____
Employee Signature Date