

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 to start this coverage at a later date.

Dependent Life Coverage:

I want Dependent Life Insurance coverage for:

Spouse Only

Spouse and Child(ren)

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 to start this coverage at a later date.

Spouse Name Date of Birth: Date of Birth: Date of Birth: Date of Birth:

Not Applicable in North Georgia

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