MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Division	Class	Dept Code
Episcopal Diocese of Dallas	05599495			
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee in blue or black ink)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female	☐ Single ☐ Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	

☑ Employee ☐ Retiree	Job Title:	Basic Annual Earnings: $	☐ Salaried ☐ Hourly	Hours Worked Per Week:

☑ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.

► If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for Supplemental/Optional Life, Supplemental/Optional Dependent Spouse/Domestic Partner Life and Supplemental/Optional Dependent Child Life.

Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?

Employee	Spouse/Domestic Partner	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **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 treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

☑ Basic Life [1] and AD&D (Core)

☐ Basic Dependent Spouse/Domestic Partner [2] Life [1,3]

☐ Basic Dependent Child Life [3]

☐ Supplemental/Optional Life [1] and AD&D (Buy up)
Enter amount requested $_____

☐ Supplemental/Optional Dependent Spouse/Domestic Partner [2] Life [1,3] and AD&D (Buy up)
Enter amount requested $_____

☐ Supplemental/Optional Dependent Child Life [3] and AD&D (Buy up)
Enter amount requested $_____

[1] 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.

[2] Domestic Partner 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. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3] Amounts will be subject to state limits, if applicable.

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ADM

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Administration, P.O. Box 14593, Lexington, KY 40512-4593
Fax MetLife at 1-888-505-7446

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%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
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 during the initial enrollment period, 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 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.
5. 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.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

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

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