

ENROLLMENT • CHANGE FORM

| GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper) | | | | |
|--|--------------------------------------|----------|-------|-----------|
| Name of Group Customer/Employer | Group Customer # | Division | Class | Dept Code |
| 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 # - - | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Address (Street, City, State, Zip Code) | | | Date of Birth (MM/DD/YYYY) | |
| <input type="checkbox"/> Employee <input type="checkbox"/> Retiree | Job Title: | Basic Annual Earnings: \$ | <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly | Hours Worked Per Week: |
| <input type="checkbox"/> New Enrollment <input type="checkbox"/> 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 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 | | | | |
| <input type="checkbox"/> Basic Life ¹ and AD&D (Core) | | | | |

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.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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. Any insurance company or agent of an insurance company who knowingly provides 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 regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company 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 and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: 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.

Maine, Tennessee 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 a denial of insurance benefits.

GEF09-1a

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



Metropolitan Life Insurance Company, New York, NY

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or 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 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: WARNING: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or 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.

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.

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%

