

## City of Tallahassee ENROLLMENT FORM FOR GROUP BENEFITS SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print) City of Tallahassee		Group Report No. 98015	Sub Division 0001	Branch 0001
Employer's Street Address 300 South Adams Stret		City Tallahassee	State FL	Zip Code 32301
Date of Hire (Mo./Day/Yr.)	Employee Base Annual Salary \$	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence <input type="checkbox"/> Late Enrollee ( <b>Statement of Health Required</b> )		Hours Worked Per Week		<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Full-Time <input type="checkbox"/> Salaried <input type="checkbox"/> Part-Time
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Late Enrollee ( <b>Statement of Health Required</b> ) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount				
Non-Medical Issue Amount for Life Benefits, if available:	<b>Insurance Amount Not Requiring Medical Underwriting</b>	<b>Insurance Amount Requiring Medical Underwriting</b>	<b>Plan Maximum</b>	
<b>For Employee:</b> Optional Life:	Coverage Amount of \$30,000 up to \$100,000	<b>NOTE: Amounts exceeding \$130,000 require a Statement of Health form.</b>	\$200,000	
<b>For Dependents:</b> Dependent Spouse:	Coverage Amount of \$15,000 up to \$50,000	N/A	\$50,000	
Dependent Child(ren):	Coverage Amount of \$5,000	N/A	\$5,000	
Signature of Employer		Print Name		Date (Mo./Day/Yr.)

## SECTION TO BE COMPLETED BY EMPLOYEE

Name (print)	First	Middle	Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Street	City		State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
E-mail Address					Phone No.(include area code) ( ) -	

### COVERAGE REQUEST DATA: EMPLOYEE COVERAGES

I have received and read a copy of my employer's current announcement of the group plan.

**I request the following coverages:**

Optional Life  \$30,000  \$50,000  \$80,000  \$100,000  \$130,000  \$150,000  \$180,000  \$200,000

Voluntary Accidental Death & Dismemberment (VAD&D) (Please complete the VAD&D section below)

I wish to decline any coverage not checked above for which I may be eligible. For Life coverage, I understand that I will be required to submit evidence of my good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired.

**Voluntary Accidental Death & Dismemberment (VAD&D)**

I understand my VAD&D benefit plan described in the announcement. I want to be covered under the group plan for which I am or may become eligible.

**VAD&D Coverage Options:**  Employee Only  Family Protection Plan Plus

**VAD&D Scheduled Plan Design:** You may elect benefit payments from \$25,000 to \$150,000 in \$25,000 increments. Your total employee coverage cannot exceed \$150,000 or 5 times your base annual salary. Coverage requested: \$ \_\_\_\_\_

**ENROLLMENT FORM FOR GROUP BENEFITS (Continued)**  
**SECTION TO BE COMPLETED BY EMPLOYEE (Continued)**

**COVERAGE REQUEST DATA: DEPENDENT COVERAGES**

I have received and read a copy of my employer's current announcement of the group plan.

**I request the following coverages:**

- Dependent Life       Spouse/Child(ren)  
 Spouse Amount (select one coverage amount): \*     \$15,000     \$25,000     \$40,000     \$50,000  
 Child Amount (select one coverage amount): \*     \$5,000

\* Amounts will be subject to state limit requirements, if applicable.

Name(s) of eligible dependent(s) for whom coverage is requested (if additional space is needed, attach a separate sheet of paper, signed and dated)

	Date of Birth (Mo./Day/Yr.)	Social Security No.
Spouse: _____	_____	_____
Child(ren): _____	_____	_____
_____	_____	_____
_____	_____	_____

I wish to decline any coverage not checked above for which I may be eligible. I understand that I will be required to submit evidence of my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired.

**DESIGNATION OF BENEFICIARY FOR EMPLOYEE LIFE BENEFITS**  
**(The Dependent Life Benefits are Payable to the Employee)**

I Designate as my Primary Beneficiary:       My Designation of Beneficiary is on a separate form which is signed, dated and attached.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
<b>TOTAL:</b>				100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
<b>TOTAL:</b>				100%

**Unless designated otherwise, payment will be made in equal shares or all to the survivor.**

I RESERVE the right to change this designation at any time.

Employee Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_  
(Mo./Day/Yr.)

**ENROLLMENT FORM FOR GROUP BENEFITS (Continued)  
DECLARATION SECTION**

**TO BE COMPLETED BY THE EMPLOYEE**

The Proposed Insured signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. The Proposed Insured understands that this information will be used by MetLife to determine his or her insurability.

**For the Employee Proposed Insured:**

I **declare** that I am actively at work on the date of this enrollment form and, for any contributory life insurance only, I have been actively at work for at least 20 hours during the 7 calendar days preceding that date. I **understand** that if I am not so actively at work on the Effective Date of my contributory life insurance only, such insurance will not take effect until MetLife receives evidence of my good health satisfactory to MetLife.

**For the Dependent Proposed Insured(s):**

I understand that, on the date a dependent insurance benefit is scheduled to take effect, I must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If I do not meet this requirement on such date, my insurance will take effect on the date I am no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

**Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility; an intermediate care facility, or a long term care facility, or receipt of chemotherapy, radiation therapy, or dialysis, wherever performed.

**For the Accelerated Benefits Option**

I **understand** that my Life Benefit includes an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. I **also understand** that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

**For Benefit Increases Requested After Initial Enrollment Period Expires**

I **understand** that if I have not elected the maximum life benefits for which I or my dependent(s) are eligible, I or my dependent(s) may be required to submit evidence of good health satisfactory to MetLife if I want to increase such benefits after my initial enrollment period has expired. I **also understand** that coverage will not take effect, or it will be limited, until I receive notice that MetLife has approved the benefit increase.

**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 are applying for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

**New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]:** 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.

**Florida:** Any person who knowingly and with 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 and Massachusetts:** 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.

**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.

**Oregon:** 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

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

If you are applying for coverage under a self-funded plan or insurance under a policy issued in any state other than those listed above, **or** if you reside in any state other than those states listed above, note the following warning:

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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:** The employee must sign in all cases.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date (Mo./Day/Yr.)



## Metropolitan Life Insurance Company Consumer Privacy Notice

Thank you for requesting insurance from Metropolitan Life Insurance Company (“MetLife”). This notice refers to MetLife as “we,” “us,” or “our.” We will evaluate your request for insurance (enrollment form and, if applicable, statement of health form) to see if you and any other person proposed for insurance (each referred to as “you” or “your”) are eligible for the insurance requested. We review all the information provided in your request for insurance and we may then confirm or add to this information in ways explained below. MetLife and each member of the MetLife family of companies (each an “Affiliate”) strongly believe in protecting the security and confidentiality of information we collect about you. This notice describes our privacy policy and how we treat the information we collect about you (“Information”).

### Consumer Privacy Notice

**Why We Collect and How We Use Information:** We collect and use Information for purposes of our insurance and other business relationships with you. These business purposes include evaluating a request for our insurance or other products or services, evaluating benefit claims, administering our products or services, and processing transactions requested by you. We may also use Information to offer you other products or services we provide.

**How We Collect Information:** If we need to verify or obtain additional Information in connection with a request for our products or services or a claim for benefits, we may do so through third parties such as adult family members, employers, other insurers, consumer reporting agencies, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations or other personal characteristics, as well as to transactions with us or with others, including our Affiliates. If we required you to sign an authorization to collect and disclose information (“Authorization”) in connection with your request for insurance, we may also obtain Information about you in accordance with the signed Authorization. For instance, we may:

- ask you to have a medical evaluation; or
- ask physicians, hospitals, or other medical care providers to confirm or add to the medical data you have given us.

**How We Protect Information:** We treat Information in a confidential manner. Our employees are required to protect the confidentiality of Information. Employees may access Information only when there is an appropriate reason to do so, such as to administer or offer our products or services. We also maintain physical, electronic and procedural safeguards to protect Information. These safeguards comply with all applicable laws. Employees are required to comply with our established policies.

**Information Disclosure:** We may disclose any Information when we believe it necessary for the conduct of our business, or where disclosure is required by law. For example, Information may be disclosed to others to enable them to provide business services for us, such as helping us to evaluate requests for insurance or benefits, and assisting us in processing a transaction requested by you. Information may also be disclosed for audit or research purposes; or to law enforcement and regulatory agencies, for example, to help us prevent fraud. Information may be disclosed to Affiliates as well as to others that are outside of the MetLife family of companies, such as companies that process data for us, companies that provide general administrative services for us, other insurers, and consumer reporting agencies. Our Affiliates include financial services companies such as life and property and casualty insurers, securities firms, broker dealers and financial advisors and may also include companies that are not financial services companies. We may make other disclosures of Information as permitted by law.

Information may be shared with our Affiliates so that they may offer you products or services from the MetLife family of companies. We may also provide Information to others outside of the MetLife family of companies such as (i) companies we engage to assist us in offering our products and services to you, and (ii) financial services companies with which we have a joint marketing agreement, for example, an agreement with another insurer to enable us to offer certain of that insurer’s products. If we enter into such a

joint marketing agreement, the agreement will provide for the protection of the confidentiality of your Information. We do not make any other disclosures of Information to other companies who may want to sell their products or services to you. For example, we will not sell your name and address to a catalogue company. We may disclose any Information, other than a consumer report or health Information, for the purposes described in this paragraph.

**Access to and Correction of Information:** Generally, upon your written request to us, we will make Information available for your review. Medical Information will generally be disclosed through the licensed physician you choose or as otherwise required by law. Information collected in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that any of the Information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of Information.

**Consumer Reports:** It is common for an insurance company to ask a consumer reporting agency to confirm and add to the Information provided in a request for insurance. Such agencies are independent and impartial. Consumer reports may reflect your mode of living, character, general reputation, personal characteristics, credit worthiness and credit standing. Information on your past and present employment, job duties, driving record, health history, use of alcohol and drugs, finances, hazardous sport activities, and marital status may be included, as well as other Information. The Information we get will be used only for business purposes related to the insurance you have requested. The Information may be kept by the agency and later given to others as permitted by the Federal Fair Credit Reporting Act and any applicable state law.

Upon your request, we will tell you whether we requested a consumer report in connection with your request for insurance. If such a report was requested, we will provide you with the name, address and telephone number of the consumer reporting agency that provided the report to us. You may contact that agency to inspect or obtain a copy of that report.

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*This notice is required by law.*

**Further Information:** This notice is a general description of MetLife’s information practices. We treat Information in accordance with all applicable laws. Such laws may provide you with additional rights. For additional information regarding our privacy policy, you may write to MetLife, P.O. Box 2006, Aurora, Illinois, 60507-2006.