METROPOLITAN LIFE INSURANCE COMPANY

One Madison Avenue
New York, NY 10010-3690

ENROLLMENT FORM FOR GROUP INSURANCE BENEFITS

SECTION TO BE COMPLETED BY EMPLOYEE

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

COVERAGE REQUEST DATA:
I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☒ Basic Life (Employer Paid)

☒ Basic Accidental Death & Dismemberment (AD&D) (Employer Paid)

Dependent Spouse Coverage

☒ Dependent Spouse Life* (Employer Paid)

Dependent Child Coverage

☒ Dependent Child Life* (Employer Paid)

*Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse) ____

Name of Spouse (Last, First, MI)	Date of Birth	Sex (M/F)

Name(s) of Child(ren) (Last, First, MI)	Date of Birth	Sex (M/F)	Is child a full-time student?
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes

DESIGNATION OF BENEFICIARY FOR EMPLOYEE LIFE BENEFITS

☐ 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 %
			TOTAL:	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 %
			TOTAL:	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.)

Please Retain A Copy Of The Fully-Completed Form For Your Records And Return The Original To Your Employer