Metropolitan Life Insurance Company
200 Park Avenue, New York, New York
1-800-638-5000

ENROLLMENT FORM FOR GROUP INSURANCE

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)
Delaware County

Employee Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip

Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	Home Phone ( )	Work Phone ( )

Spouse Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Dependent Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Dependent Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Dependent Last Name	First Name	Middle Initial	Social Security Number	Date of Birth
Dependent Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Group Term Life

Effective Date	Type of Coverage	Amount of Coverage	Total Premium
	Basic Group Life/AD&D ☒ **Yes** ☐ **No**	**1x Annual Salary**	Employer Paid

Voluntary Coverage

NOTE: Please mark the box or boxes for each coverage you are applying for. You may only purchase half of what you have for your spouse. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

By selecting "No" below, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life/AD&D Insurance ☐ **Yes** ☐ **No**	$	$
Voluntary Spouse Life/AD&D Insurance ☐ **Yes** ☐ **No**	$	$
Voluntary Dependent Child Benefit* ☐ **Yes** ☐ **No** *one rate for all eligible children	**$10,000**	$

--Actual deductions may vary slightly from above illustrations due to rounding—

Beneficiary Information

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	%
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	%
Street Address			City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number	%
Street Address			City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please complete as above and/or attach a separate sheet of paper.

NOTE: ANY PERSON WHO, WITH 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 IS GUILTY OF INSURANCE FRAUD.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The MetLife Insurance Company, or its insurance partners, and the initial premium is paid to The MetLife Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Signature:_____ Print Name:_____ Date:_____