

OPTIONAL DEPENDENT DEATH BENEFIT



Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR THE PENSION BOARDS-UNITED CHURCH OF CHRIST, INC.

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print)		Group Report No. 22196	Sub Division	Branch
Employer's Street Address		City	State	Zip Code Employee Work Location
Date of Hire (Mo./Day/Yr.)	Employee Basic Annual Earnings (BAE) \$	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		Hours Worked Per Week:	<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Salaried	<input type="checkbox"/> Full-Time <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 (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) 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:

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 which I am or may become eligible, requested below.

I request the following coverage:

Dependent Spouse/Same-Gender Domestic Partner Coverage

Dependent Spouse/Partner Life* \$10,000 \$25,000 (Note: Coverage amounts exceeding \$10,000 require a Statement of Health form.)

Dependent Child Coverage

Dependent Child Life* \$5,000 \$10,000

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

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

Number of dependents (including spouse)

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

Spouse/Partner: _____

Child(ren): _____

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren) Name of School

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?

Spouse Yes No Child(ren) Yes No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date.

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.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect 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.

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 reside in or are applying for insurance under a policy issued in one of the following states, please read the 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.

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.

Kansas, Oregon, Washington and Vermont: 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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:

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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature

Print Name

Date (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature

Print Name

Date (Mo./Day/Yr.)

Other Signature

Print Name

Date (Mo./Day/Yr.)

If a stepchild is included above, his or her natural parent must sign below:

Signature of Natural Parent

Print Name

Date (Mo./Day/Yr.)

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of **METROPOLITAN LIFE INSURANCE COMPANY**.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about your finances, employment, hobbies, mode of living, work history, and driving record.

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. Please identify the specific product or service you are writing about.



Metropolitan Life Insurance Company, New York, NY

DOMESTIC PARTNER DECLARATION

This declaration is to be completed by both the employee and the declared Domestic Partner.

We declare that:

- (1) we have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations which has existed for at least 6 months prior to the enrollment of the Domestic Partner for MetLife coverage(s) and which is expected to last indefinitely;
- (2) we have shared the same residence for at least 6 months prior to the enrollment of the Domestic Partner for MetLife coverage(s);
- (3) we are each **18 years of age or older**;
- (4) neither of us is **married**;
- (5) we are **not related** by blood in a manner that would bar our marriage in the state in which we reside (does not apply to Maine residents);

We also declare that two or more of the following exist as evidence of joint responsibility for basic financial obligations:

- joint mortgage or lease
- designation of the Domestic Partner as durable power of attorney or health care proxy
- joint wills or designation of the Domestic Partner as executor and/or primary beneficiary
- joint bank account, joint credit cards or other evidence of joint financial responsibility
- designation of the Domestic Partner as beneficiary for life insurance or retirement benefits
- other evidence that establishes economic interdependence (please specify below).

We have read and understand the terms and conditions contained in this declaration. We understand that any misrepresentation of fact can result in loss of coverage and liability for incorrect insurance benefit payments.

(1) Print Employee Name: _____

Employee Signature: _____ DATE: _____

(2) Print Domestic Partner Name: _____

Domestic Partner Signature: _____ DATE: _____

Important Notice: You may want to seek legal advice before signing this declaration to ensure that you understand the possible legal effects of this acknowledgment of a Domestic Partner relationship.

Return the original copy of this declaration to your employer.