MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Scott and White HealthPlus	5463001			
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event 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 that contributions are required for the benefits I select below. I have received and read a copy of the Outline of Coverage or other disclosure document for the Accident Insurance and Critical Illness Insurance. In certain states, this coverage may be referred to as Critical Illness Insurance, Specified Disease Insurance, Limited Benefit Insurance or Limited Benefit Critical Illness Insurance.

► If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form.

Term Life Insurance

☐ Supplemental/Optional Life [1]
☐ $10,000 ☐ $30,000 ☐ $50,000

☐ Dependent Spouse/Domestic Partner [2] Life [1,3]
☐ $5,000 ☐ $15,000 ☐ $25,000

☐ Dependent Child Life [3]
☐ $5,000 ☐ $10,000

Accidental Death & Dismemberment (AD&D) Insurance

☐ Supplemental/Optional AD&D ☐ Dependent Spouse/Domestic Partner [2] AD&D ☐ Dependent Child AD&D

Accident Insurance

First select your option
☐ Low Plan
☐ High Plan

Then select your level of coverage
☐ Employee Only
☐ Employee + Spouse/Domestic Partner [2]
☐ Employee + Child(ren)
☐ Employee + Spouse/Domestic Partner [2] + Child(ren)

Critical Illness Insurance

First select your option
☐ $10,000
☐ $20,000

Then select your level of coverage
☐ Employee Only
☐ Employee + Spouse/Domestic Partner [2]
☐ Employee + Child(ren)
☐ Employee + Spouse/Domestic Partner [2] + Child(ren)

[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.

[2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to:
Scott and White, 1206 West Campus Drive, Temple, TX 76502.

Dependent Information		
If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:		
Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.		

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.

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.

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.

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.

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.

GEF09-1
FW

BENEFICIARY DESIGNATION FOR MEMBER 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. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.
☐ 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%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, 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. 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 treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for 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.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC