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
Garland Independent School District	**90285**			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		

Date of Birth (MM/DD/YYYY)	Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) $
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.

► If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for GUL, Dependent Spouse GUL and Dependent Child Life.

Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?

Employee	Spouse	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **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.

► If you are enrolling during the initial enrollment period, you must complete the Health Information section of this form and the enclosed Authorization form:
- If you are enrolling for more than 2x your Basic Annual Earnings or an amount of more than $100,000 but less than $450,000 of GUL Insurance
- If you are enrolling for more than $20,000 of Dependent Spouse GUL Insurance

► If you are enrolling during the initial enrollment period, you must complete a Statement of Health form:
- If you are enrolling for more than $450,000 of GUL Insurance or answer "yes" to the 90 day hospitalization or any of the Health Information questions.
- If you are enrolling for Dependent Spouse GUL Insurance and answer "yes" to the 90 day hospitalization or any of the Health Information questions.

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Group Universal Life (GUL) Insurance

☐ GUL [1]

☐ 1x ☐ 2x ☐ 3x Basic Annual Earnings up to a maximum of $900,000

Monthly Contribution to the GUL Cash Fund: ☐ $0 ☐ $10 ☐ $15 ☐ $25 ☐ Other: _____ ☐ Discontinue

☐ Dependent Spouse [2] GUL [1, 3]

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Monthly Contribution to the GUL Cash Fund: ☐ $0 ☐ $10 ☐ $15 ☐ $25 ☐ Other: _____ ☐ Discontinue

Term Life Insurance

☐ Dependent Child Life [3]

☐ $5,000 ☐ $10,000

[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. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Spouse 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.

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

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SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Recordkeeping Center, P. O. Box 14402, Lexington, KY 40512-4402.
If you have any questions, call the MetLife Benefits Line at 1-800-523-2894.

Garland Independent School District
EF-XDR125M-DE-HI-IL-NV-RI-WA (04/16)

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Social Security # | ☐ 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.

Smoking Status Information

	Employee	Spouse
Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?	☐ Yes ☐ No	☐ Yes ☐ No

If you are changing smoking status

Status is changing from: ☐ Smoker to Non-Smoker ☐ Non-Smoker to Smoker Change is for: ☐ Employee ☐ Spouse

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HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

	Employee	Spouse
1. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐Yes ☐No	☐Yes ☐No
2. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐Yes ☐No	☐Yes ☐No
3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐Yes ☐No	☐Yes ☐No
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. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐Yes ☐No	☐Yes ☐No
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐Yes ☐No	☐Yes ☐No
b. stroke or circulatory disorder?	☐Yes ☐No	☐Yes ☐No
c. high blood pressure?	☐Yes ☐No	☐Yes ☐No
d. cancer, Hodgkins disease, lymphoma or tumors?	☐Yes ☐No	☐Yes ☐No
e. anemia, leukemia or other blood disorder?	☐Yes ☐No	☐Yes ☐No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

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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.

BENEFICIARY DESIGNATION FOR EMPLOYEE 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 Employee.

☐ 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, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
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.
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 Employee	Print Name	Date Signed (MM/DD/YYYY)

Sign Here

Signature of Owner, if coverage was Assigned	Print Name	Date Signed (MM/DD/YYYY)

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DEC

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information; medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Heath Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Employee _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

Sign Here

Signature of Spouse _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

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