MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM - Active Employee

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
The City of Marlborough	**149750**	**149750**	**0003**	**0001**

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

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)	

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 no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

- ► If you are enrolling during the initial enrollment period, you must complete a Statement of Health form if you are enrolling for more than $100,000 of Supplemental/Optional Life Insurance.
- ► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic Life [1] / Basic AD&D

☐ Supplemental/Optional Life [1] / Supplemental/Optional AD&D
Enter a multiple of $10,000 up to a maximum of $250,000. $_____

☐ Dependent Spouse [2] Life [1,3] / Dependent Spouse AD&D
☐ $10,000 ☐ $25,000, not to exceed 100% of your Supplemental/Optional Life Insurance.

☐ Dependent Child Life [3] / Dependent Child AD&D

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)	
		☐ 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.

[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] For Washington State residents, 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.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			**TOTAL:**	**100%**

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			**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.
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

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

City of Marlborough
Personnel Department
140 Main Street
Marlborough, MA 01752
Telephone (508) 460-3705, Facsimile (508) 481-6354

DAVID B. BRUMBY
PERSONNEL DIRECTOR

MARY WARD
PERSONNEL ASSISTANT

DIANE REGO
ADMINISTRATIVE CLERK

Additional Life Insurance for Active Employees, Employees' Spouses and Children

We are please to announce that The City of Marlborough is offering voluntary life insurance for active (benefit eligible) employees through MetLife. This is **Guaranteed Issue - no medical underwriting required for amounts up to $100,000.** Employees can purchase $10,000 thru $250,000 of coverage; however anything over $100,000 will require medical underwriting. In addition, employees can purchase a **guaranteed issue** amount of $10,000 or $25,000 of coverage for their spouse and $10,000 for children.*

No medical underwriting required for amounts up to $100,000 if enrollment is done at time of hire.

COVERAGE OPTIONS & COST:

Employee Optional Life	**Monthly Rate**	**Weekly Rate**	**B-Weekly Rate**
$10,000	**$7.20**	**$1.66**	**$3.32**
$20,000	**$14.40**	**$3.32**	**$6.65**
$50,000	**$36.00**	**$8.31**	**$16.62**
$100,000	**$72.00**	**$16.62**	**$33.23**
Any amount not list above can be calculated by multiplying .72 per 1,000 of coverage			

Dependent Life*			
Spousal Coverage*			
$10,000	**$5.18**	**$1.20**	**$2.39**
$25,000	**$12.95**	**$2.99**	**$5.98**
Child Coverage*			
$10,000	**$2.15**	**$0.50**	**$0.99**

Coverage Features:

- Waiver of Premium is included
- Coverage can be carried into retirement up until age 75 at the guaranteed rate.
  At age 75, the coverage can be ported or converted to a permanent plan based on the table rates.
  For Employees who leave the group - coverage can be ported or converted to a permanent plan at the table rates.

Conditions:

- 2 year suicide exclusion

***Spousal & Children coverage can only be purchased if the employee is purchasing coverage for themselves.**