

## ENROLLMENT • CHANGE FORM - Retirees

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)				
Name of Group Customer/Employer <b>The City of Marlborough</b>	Group Customer # <b>149750</b>	Report # <b>149750</b>	Sub Code <b>0004</b>	Branch <b>0001</b>
Date of Hire (MM/DD/YYYY)		Coverage Effective Date (MM/DD/YYYY)		

YOUR ENROLLMENT INFORMATION (To be Completed by the Retiree)			
Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	
<b>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&amp;D. I understand that contributions are required for the benefits I select below.</b> ► If you are enrolling during your initial retiree enrollment period, you must complete a Statement of Health form if you are currently enrolled for Supplemental/Optional Life Insurance and requesting an increase.			
<b>Term Life Insurance and Accidental Death &amp; Dismemberment (AD&amp;D) Insurance</b>			
<input checked="" type="checkbox"/> Basic Life <sup>1</sup> / Basic AD&D <input type="checkbox"/> Supplemental/Optional Life <sup>1</sup> / Supplemental/Optional AD&D <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$12,500 <input type="checkbox"/> Amount in effect on your last day of employment			

<sup>1</sup> 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.

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 insurance policy under which you are applying for coverage was issued.

**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:** A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing 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 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, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

GEF09

FW

### SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

**The City of Marlborough (Retirees)**  
EF-XDP101M-NW (08/12)

**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 (AD&D/Disability/Dental)]: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each 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 and 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.

**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.

**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

FW

## BENEFICIARY DESIGNATION FOR RETIREE INSURANCE

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 have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

			
	Signature of Retiree	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 BRUMBY**  
PERSONNEL DIRECTOR

**MARY WARD**  
PERSONNEL ASSISTANT

**DIANE REGO**  
SENIOR CLERK

**CITY OF MARLBOROUGH**  
**LIFE INSURANCE RATES FOR RETIREES**

<u>Type of Coverage</u>	<u>Monthly Deduction</u>
Basic \$5,000	\$4.77
<i>Optional Coverage:</i>	
\$5,000	\$3.60
\$12,500	\$9.00
\$17,500	\$12.60

For any optional coverage amount not listed above, the cost is \$.72 per 1,000 of coverage.