MetLife
Metropolitan Life Insurance Company, New York NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
California School Employees Association	**220355**			
Date of Membership (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

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 I am enrolling for Hospital Indemnity Insurance: I declare that all individuals to be insured have comprehensive medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses. If I am enrolling for Critical Illness: I declare that all individuals to be insured have comprehensive medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses. I have received and read a copy of the Outline of Coverage or other disclosure document for the Hospital Indemnity Insurance. I have received and read a copy of the Outline of Coverage or other disclosure document for the 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.

The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Hospital Indemnity Insurance

First select your option
- ☐ Low Plan
- ☐ High Plan

Then select your level of coverage
- ☐ Member Only
- ☐ Member + Spouse/Domestic Partner [1]
- ☐ Member + Child(ren)
- ☐ Member + Spouse/Domestic Partner [1] + Child(ren)

Critical Illness Insurance

First select your option
- ☐ $15,000
- ☐ $30,000

Then select your level of coverage
- ☐ Member Only
- ☐ Member + Spouse/Domestic Partner [1]
- ☐ Member + Child(ren)
- ☐ Member + Spouse/Domestic Partner [1] + Child(ren)

[1] 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 if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF02-1 ADM** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

After completion, **sign and date the form where indicated**. Make a copy for your records and return to
Forrest T. Jones & Company, ATTN: Admin-FP, 3130 Broadway Blvd., Kansas City, MO 64111
Or Fax to: 816-751-6092. For questions please call 800-821-7303.

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
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GEF09-1 *applies to residents of Louisiana and Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

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.

Kansas and 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.

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.

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.

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 FW** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
FW *applies to residents of North Dakota and Utah)*

MetLife
Metropolitan Life Insurance Company, New York NY 10166

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

Your Hospital Indemnity and Critical Illness certificate provides limited benefits. Read your certificate carefully.
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. 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 have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

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

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 DEC** *applies to residents of Oregon*;
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

California School Employees Association (Members)
EF-AA-ST966M-CA (05/19)

Payment Information

I am selecting the following payment option (check one of the boxes below) and am including a completed EFT authorization:
Select payment preference: ☐ EFT ☐ Periodic Billing
For EFT, select frequency of payment: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual
For Periodic Billing, select frequency of billing: ☐ Annual ☐ Semiannual ☐ Quarterly