MetLife®
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR RESEARCH FOUNDATION OF MENTAL HYGIENE

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print)		Group Report No.	Sub Division	Branch
RESEARCH FOUNDATION OF MENTAL HYGIENE		**117655**		
Employer's Street Address 150 Broadway Suite 301	City Menands	State NY	Zip Code 12204	Employee Work Location
Date of Hire (Mo./Day/Yr.)	Employee Base Annual Salary (BAS) $	Employee's Occupation:	Coverage Effective Date (Mo./Day/Yr.):	
Work Status: ☒ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence		Hours Worked Per Week:	☐ Hourly Paid ☒ Salaried	☐ Full-Time ☐ Part-Time
Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Late Enrollee **(Statement of Health Required)** ☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount ☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____				

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City State Zip Code		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-mail Address		Phone No. (include area code)	

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☒ Basic Life (Employer Paid up to a maximum of $80,000) ☒ Accidental Death & Dismemberment (AD&D) (Employer Paid)

☐ Optional Life (You may elect coverage from 1x to 3x your Base Annual Salary up to a maximum of $380,000, combined with Basic Life Insurance.
Note: Coverage amounts exceeding $150,000 require a Statement of Health form) ☐ 1x ☐ 2x ☐ 3x Base Annual Salary

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form? **Employee** ☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

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DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date. If Hospitalized during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of good health satisfactory to MetLife.

For the Accelerated Benefits Option

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. Receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

(Continued on Following Page)

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect 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.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

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 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.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas and Oregon: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

In any other case, read the following warning.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %

If 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 (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
			TOTAL:	100%

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature _____ Print Name _____ Date (Mo./Day/Yr.) _____