

ENROLLMENT • CHANGE FORM**ENROLLMENT PERIOD FROM FEBRUARY 1, 2011 – FEBRUARY 15, 2011**

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)				
Name of Group Customer/Employer Eastern Michigan University	Group Customer # 103904	Report #	Sub Code	Branch

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)			
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	

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. I understand that contributions are required for the benefits I select below.

- ▶ You must complete the Health Information section of this form and the enclosed Authorization form:
- if you are enrolling for more than \$200,000 of Supplemental/Optional Life Insurance,
 - if you are enrolling for more than \$15,000 of Dependent Spouse/Domestic Partner Life Insurance.

Term Life Insurance

- Basic Life ¹
- Supplemental/Optional Life ¹
Enter a multiple of \$10,000 up to a maximum of \$500,000. \$ _____
- Dependent Spouse/Domestic Partner Life ^{1,2}
 \$15,000 \$50,000 \$100,000
Maximum coverage amount cannot exceed 100% of your Supplemental/Optional Life coverage.
- Dependent Child Life ²
 \$10,000 \$15,000

Accidental Death & Dismemberment (AD&D) Insurance

- Supplemental/Optional AD&D
Enter a multiple of \$10,000 up to a maximum of \$500,000. \$ _____

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.

² Amounts will be subject to state limits, if applicable.

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Recordkeeping Center, P.O. Box 6170, Utica, NY 13504

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)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____	_____		
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male	<input type="checkbox"/> 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.

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ADM

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/ Domestic Partner
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you now receiving or applying for any disability benefits, including workers' compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days? 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. stroke or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. cancer, Hodgkins disease, lymphoma or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. anemia, leukemia or other blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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. Upon receipt of this form by MetLife, a Statement of Health form will be sent to you for completion and return to MetLife.

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HEA

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.

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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.

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.

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BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE				
<p>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.</p>				
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%

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DEC

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.



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

AUTHORIZATION

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
 - 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; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, 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.

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

	_____ Signature of Spouse	_____ Date Signed (MM/DD/YYYY)
	_____ Print Name	_____ State of Birth

	_____ Signature of Child #1 or Signature & Relationship of Personal Representative*	_____ Date Signed (MM/DD/YYYY)
	_____ Print Name	_____ State of Birth

	_____ Signature of Child #2 or Signature & Relationship of Personal Representative*	_____ Date Signed (MM/DD/YYYY)
	_____ Print Name	_____ State of Birth

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.