



ENROLLMENT/CHANGE FORM

New Enrollment Change

EMPLOYEE NAME – LAST	FIRST	M.I.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
HOME ADDRESS			CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.		EARNINGS: \$ _____		<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>
EMPLOYER: Region VII Employee Benefits Cooperative				School District: Sabine ISD	

COVERAGE SELECTION: Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

BASIC COVERAGE <input type="checkbox"/> Basic Term Life/AD&D		[AMOUNT OF COVERAGE] \$ _____			
VOLUNTARY TERM LIFE COVERAGE: (Evidence of Insurability may be required on employee and spouse life)		(A)dd (C)hange (D)elete	Total Amount of Coverage Applied	If (C), my prior coverage was	My Monthly Cost.
Voluntary Term Life/AD&D: Employee	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____		
Voluntary Term Life/AD&D: Spouse	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____		
Voluntary Term Life: Dependent Child(ren)	<input type="checkbox"/> YES <input type="checkbox"/> NO		\$ _____		

BENEFICIARY DESIGNATION 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. The Employee understands that he or she has the right to change this designation at any time.

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%
Contingent					%

Enrollment / Change – Voluntary Dental Coverage

<input type="checkbox"/> New Employee	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> COBRA	
<input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Employee <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	<u>Monthly Cost</u> \$22.95 \$53.01 \$52.22 \$79.95 Rates are guaranteed until August 31st, 2009.	<input type="checkbox"/> Policy Change (check reason for change) <input type="checkbox"/> Married <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Address Change	<input type="checkbox"/> Cancel Coverage <input type="checkbox"/> Terminate Coverage Date: _____ <input type="checkbox"/> Other: Date: _____

DEPENDENTS TO BE COVERED FOR DENTAL

Name (First MI Last, only if different)	Date of Birth	Relationship	Sex	Check if over age limit
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Handicapped child

COBRA Continuation Privilege: Start Date: ____ / ____ / ____ Projected End Date: ____ / ____ / ____	Previously covered with group as: <input type="checkbox"/> 1. Employee (termination of employment, reduction in hours, other.) <input type="checkbox"/> 2. Spouse (divorce from employee, death of employee.) <input type="checkbox"/> 3. Dependent (reached age limit, married, no longer full-time student, other.) <input type="checkbox"/> 4. Spouse & Dependents (divorce from employee, death of employee, other.)
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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 and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

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

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 insurability 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.

Texas:

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 may be a crime and may subject such person to criminal and civil penalties.

EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____