

ENROLLMENT FORM FOR GROUP INSURANCE
SECTION TO BE COMPLETED BY C.A.R. Member/Employee (PLEASE PRINT)



| | | | | |
|--|---|--|---|--|
| Name of Employee (Last, First, Middle) | | Social Security No. | Date of Birth (Mo./Day/Yr.) | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Employee's Address Street City State Zip Code | | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | |
| Employee's E-mail Address | | Phone No. (include area code) | | |
| Name of Association/Employer California Association of REALTORS® | | Customer Number TS05726225 | Division | Class Dept Code |
| Employer's Street Address City State | | Zip Code | Employee's Work Location | |
| C.A.R. Join Date/Date of Hire (Mo./Day/Yr.) | <input checked="" type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time | Employee's Occupation | | Coverage Effective Date (Mo./Day/Yr.) |
| Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence | | Hours Worked Per Week | <input type="checkbox"/> Hourly Paid <input type="checkbox"/> Annual <input type="checkbox"/> Monthly | Salary \$ |
| <input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____ | | | | |
| Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required for Life Insurance) <input type="checkbox"/> Change in Plan <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____ | | | | |

COVERAGE REQUEST DATA:

I have received and read a copy the enrollment and plan information for the C.A.R. group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee/Member Coverage

- Optional Life/Accidental Death & Dismemberment (AD&D): Coverage Requested \$25,000 \$50,000
 Dental Dual Option (Select one option): Standard Plus Plan Standard Basic Plan Premier Plus Plan Premier Basic Plan

Dependent Spouse Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)

- Dental Option

Dependent Child Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)

- Dental Option

I wish to **DECLINE** any coverage not checked above for which I may be eligible. For Life, I understand that I will be required to submit evidence of my good health satisfactorily to MetLife if I request this coverage after my initial period for enrollment has expired. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)

Name of Spouse (Last, First, MI) Date of Birth Sex (M/F)

| | | |
|--|--|--|
| | | |
|--|--|--|

Name(s) of Child(ren) (Last, First, MI) Date of Birth Sex (M/F) Is child a full-time student?

| | | | |
|--|--|--|------------------------------|
| | | | <input type="checkbox"/> Yes |
| | | | <input type="checkbox"/> Yes |
| | | | <input type="checkbox"/> Yes |
| | | | <input type="checkbox"/> Yes |

For new C.A.R. Members/Employees electing Life Insurance, please answer the following question:

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 any 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.

Return your completed enrollment form and initial premium payment to:
RealCare Insurance Marketing, Inc. 19310 Sonoma Highway, Suite A. Sonoma, CA 95476 or call (800) 939-8088
Check should be made payable to R.I.T.A. (RealCare Insurance Trust Account)



Application Checklist

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment (**even if you are selecting the Automatic Premium Payment option**). Include premiums for all applicable insurance plans (medical, dental, vision, and life insurance). If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application**. After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare, to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose a **voided check** and complete the form below and return to RealCare with your initial premium check. **The initial premium must be submitted even if you select the Automatic Premium Payment option.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088 Ext. 202

Mail Applications to:
RealCare Insurance Marketing, Inc.
19310 Sonoma Hwy. Ste. A
Sonoma, CA 95476

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues and/or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month following the due date. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the fifth of the month following the due date. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

| | |
|---------------------------------|----------------------|
| Policyholder Information | |
| Policyholder name: _____ | Phone: _____ |
| Social Security Number: _____ | Email Address: _____ |

**PLEASE
ATTACH A
COPY OF
YOUR VOIDED
CHECK AND
SUBMIT WITH
YOUR
ENROLLMENT
APPLICATION.**

| | |
|--|--|
| Banking Information | |
| Name of bank or financial institution: _____ | |
| Bank Account Name: _____ | |
| <input type="checkbox"/> Checking Account | <input type="checkbox"/> Savings Account |
| Account Number: _____ | |
| Bank Routing Number: _____ | |

| | |
|--|-------------|
| Authorized Signature | |
| _____ | Date: _____ |
| Authorized Signature <i>(As it appears in the financial institution's records)</i> | |

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. This does not apply to replacement contracts.

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.

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 an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life or disability 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. I also **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

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, Oregon, and Vermont: 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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

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Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.