MetLife Dental & Vision Enrollment & Change Form

For members of the California Association of REALTORS®

Special Notes for MetLife Application

General Information

- Fill in your personal information and provide your email address. We will frequently communicate with you via email so your email address is important.

Enrollment Instructions

1. Complete/Sign enrollment form
    - Check "Enroll" at top of page and fill in the Requested Effective Date
    - Complete your person information
    - Select the Dental and/or Vision plans you want to enroll in
    - Enter your dependent information (including date of birth and gender)
    - Sign and date page 2
2. Send check for payment of one month's premium + administrative fee; made payable to "RealCare Insurance Trust Account"
3. OPTIONAL: Complete/Sign Automatic Premium Payment Authorization *and with a voided check* to set up automatic payments
4. Return all items via *one* of the methods below.

Making Changes

To change plans or add/drop dependents:

1. Complete/Sign enrollment form
    - Check appropriate change at top of form and fill in the Requested Effective Date
    - Complete your personal information
    - If making a plan change, select your new plan
    - If adding/dropping dependents, select the plans you currently have
    - Enter your dependent information (including date of birth and gender)
    - Sign and date page 2
2. Return the completed form to RealCare, via *one* of the methods below.

Submit Completed Application WITH Initial Payment

- Include the initial month's premium payment
- If submitting application via FAX or EMAIL, add a $5.00 electronic check fee to your total premiums
- If enrolling in Automatic Premium Payment Authorization, you must include a voided check

Make your check payable to: RealCare Insurance Trust Account (R.I.T.A.)

Mail To:
430 West Napa Street, Suite F
Sonoma, CA 95476

Fax to:
(707) 939-8450

Email to:
Enrollment@RealCare.biz

Check One

Enroll:_____ Add Dependents:_____ Drop Dependents:_____ Plan Change:_____

(Enter dependent information below)

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

Requested Effective Date: _____

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Customer	Group Customer #
California Association of REALTORS®	5726225
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.

Dental Insurance

First select your option

- ☐ Choice Plan
- ☐ Select Plan
- ☐ Value Plan

Then select your level of coverage

- ☐ Member Only
- ☐ Member + Child(ren)
- ☐ Member + Spouse/Domestic Partner[1]
- ☐ Member + Spouse/Domestic Partner[1] + Child(ren)

Vision Insurance

First select your option

- ☐ Enhanced Plan
- ☐ Basic Plan

Then select your level of coverage

- ☐ Member Only
- ☐ Member + Child(ren)
- ☐ Member + Spouse/Domestic Partner[1]
- ☐ Member + Spouse/Domestic Partner[1] + Child(ren)

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.

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

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records. If you have questions, please contact:
RealCare Insurance Marketing, 430 W. Napa, Suite F, Sonoma CA 95476 or fax to 707-935-7142. Questions 800-939-8088

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

FRAUD WARNING

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. 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: **GEF09-1** *applies to residents of Montana*;
GEF09-1
FW *applies to residents of North Dakota and Utah)*

DECLARATIONS AND SIGNATURE

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.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
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: **GEF09-1** *applies to residents of Montana*;
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

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/fees 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 check for your first premium payment PLUS **a voided check.** Complete the form below and return to RealCare with your initial premium check**.**
- 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

Submit Completed Application and Initial Payment

Mail To:
430 West Napa Street, Suite F
Sonoma, CA 95476

Fax to:
(707) 939-8450

Email to:
Enrollment@RealCare.biz

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 prior to the month of coverage. 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 first of the month of coverage. 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: _____

Banking Information

Name of bank or financial institution:_____

Bank Account Name: _____

☐Checking Account ☐Savings Account Account Number: _____

Bank Routing Number:_____

Authorized Signature

_____ Date:_____

Authorized Signature
(As it appears in the financial institution's records)

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

Note: There is a $5.00 Electronic Check Fee for payments submitted via fax or email. Please add this amount to your total premium for the initial payment.