NEW MEMBERS/EMPLOYEES: Use this form to enroll for Life and AD&D Insurance.
EXISTING MEMBERS/EMPLOYEES: If enrolling for Life insurance more than 31 days after your eligibility date, you will also be required to submit a Statement of Health form.

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Plan Administrator in blue or black ink)

Name of Association/Employer	Customer #	Division	Class
California Association of REALTORS®	TS05726225		

Association/Employer Address (Street, City, State, Zip Code)	Member/Employee Work Location

Date of Membership/Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Member/Employee in blue or black ink)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)

Address (Street, City, State, Zip Code)	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Work Status: ☐ New Hire ☐ Active ☐ Rehire	☐ Full-Time ☐ Part-Time	Member/Employee Occupation:	Hours Worked Per Week:

Phone #	Email Address	Reason for Enrollment: ☐ New Coverage ☐ New Hire First Time Eligible ☐ Change in Plan ☐ Late Enrollee (Statement of Health Required)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.

► If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for Supplemental/Optional Life.
Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?

Member/Employee
☐ Yes ☐ No

If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **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.

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

☐ Supplemental/Optional Life [1] and Accidental Death and Dismemberment (AD&D)
☐ $25,000 ☐ $50,000

[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. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF02-1
ADM *applies to residents of Connecticut, 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

California Association of REALTORS®
EF-ST441S-CA (10/18)

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

FRAUD WARNINGS

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: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

BENEFICIARY DESIGNATION FOR MEMBER/EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time.
☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

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. If I am an employee, I declare that I am actively at work on the date I am enrolling.
3. 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.
4. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

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

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*