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.

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 **California Association of REALTORS®**	Customer # **05726225**	Division	Class
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	CA Real Estate License #	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 that contributions are required for the benefits I select below.

► If you are enrolling during the initial eligibility 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

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.

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)*

Some services in connection with your coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

APPLICATION CHECKLIST

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- **Enclose the initial month's premium payment**. Your payment must include premiums and fees for all applicable insurance plans (medical, dental, vision, and life insurance).
- If paying monthly by Automatic Premium Payment, complete the form below and include your initial premium payment and a **voided check** with your submission.
- 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.).
- RealCare is required to verify your eligibility. If we cannot verify your membership online, you will be required to submit **proof of eligibility.** If you are a W-2 employee of a C.A.R. member or Board, you are required to submit payroll records or other documentation to verify eligibility.
- 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. **Documentation of your qualifying event is required to enroll.**

Submit Completed Application and Initial Payment

Mail To:	Fax to:	Email to:
430 West Napa Street, Suite F Sonoma, CA 95476	(707) 939-8450	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 initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. 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 RealCare 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.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: ____

Phone: ___________________________ Email Address: _______________________________________

Banking Information

Name of Bank or Financial Institution: ____

Name on Bank Account: ____

Bank Routing Number: ____ ☐Checking Account

Account Number: ____ ☐Savings Account

Authorized Signature

____ Date:_____________________

Signature of Authorized Signer on Above Bank Account

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

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

Note: The $5.00 Electronic Check Fee normally charged for payments submitted via fax or email is *waived* for the initial payment.