MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Division	Class	Dept Code
California Association of REALTORS®	**TS05726225**			
Date of Membership/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	☐ Single ☐ Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	CA Real Estate License#

☐ Member ☐ Employee	Job Title:	Basic Annual Earnings: $	☐ Salaried ☐ Hourly	Hours Worked Per Week:

☐ 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 the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.

Accidental Death & Dismemberment (AD&D) Insurance

☐ Voluntary AD&D

First select your option

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

Then select your level of coverage

- ☐ $250,000 ☐ $500,000

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
		☐ 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: 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 and return the original to:
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 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 affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. 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)

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GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*