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 Cus		mer#	Division	Class	Dept Code			
California Association of REALTORS®					225				·			
Date of Membership/Hire	e (MM/D	DD/YYYY)		Coverage Effective Date (MM/DD/YYYY)								
YOUR ENROLL	MEN	T INFORMATION (To be	Com	pleted by	/ the	e Mem	ber/Employee	in blue or bla	ck 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				ic Annual Earn		gs:	Salaried Hourly	Hours Worked Per Week:				
☐ New Enrollment	Chan	ige in Enrollment						1				
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 Partner¹ + Child(ren) (Family) Then select your level of coverage \$250,000												
Dependent Information												
Name of your Spouse/Do	omestic	ge for your Spouse/Domestic Part Partner (First, Middle, Last)	iner an		ate	of Birth (I	provide the infor MM/DD/YYYY) MM/DD/YYYY)		d below: Male ☐ Female			
Name(s) of your Child(re	ii) (Fiis	t, Middle, Last)		D	ale	ו) ווווום וט	VIIVI/UU/TTTT)		Mala 🗆 Famala			
-									Male ☐ Female Male ☐ Female			
									Male			
									Male Female			
									Male Female			
Check here if you ne	ed more	e lines. Provide the additional inform	nation o	on a separa	ıte pi	iece of pa	aper and return it w					
reciprocal beneficiaries v you and your Domestic F interest in the continued	vith a go Partner l life, hea blemen	registered Domestic Partner if you a overnment agency or office where su have either a substantial interest in t alth or bodily safety of each other, as t or injury of the other person. By er	uch reg the others disting	istration is er engende quished from	avail red b n an	lable. It a by love a i interest	also includes your on a land affection; or a land which would arise	non-registered Do awful and substar only by, or would	omestic Partner if Itial economic be enhanced in			

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

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

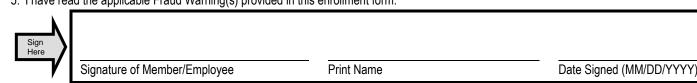
FW applies to residents of Connecticut, North Dakota and Utah)

BENEFICIARY DESIGNATION FOR MEMBER 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:											

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.



GEF09-1a

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; **GFF09-1**

DEC applies to residents of Connecticut, North Dakota and Utah)