

MetLife Supplemental Life and AD&D Enrollment Form

For members of the California Association of REALTORS®

Special Notes for MetLife Application

General Information

- **New members and eligible employees** may enroll in the C.A.R. life insurance program on a guaranteed basis after one month of C.A.R. membership or employment. **Life insurance coverage is only guaranteed if application is received within 31 days of the Coverage Eligibility Date and if the enrollee has not been hospitalized within 90 days of making application. Members who enroll more than 31 days after the Coverage Eligibility Date will be required to submit a Statement of Health application and could be declined due to health history.**
- 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
 - Complete the “Coverage Effective Date” at the top of the form. Your effective date is determined by your eligibility date or qualifying event date.
 - Complete your person information.
 - Check
 - “New Hire First Time Eligible” if you are a new member or employee. ” in the “Your Enrollment Information” section.
 - “Late Enrollee” if applying outside of your initial eligibility period. ***If enrolling outside of initial eligibility period, please also submit the Statement of Health form.***
 - Answer the question on hospitalization
 - Check the amount of coverage you want
 - Complete the Beneficiary Designation section. If you need space to add additional beneficiaries, contact RealCare.
 - Sign and date the application.
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 submit with a voided check to set up automatic payments
4. Return all items via one of the methods below. (*Email submission is preferred*)

Submit Completed Application WITH Initial Payment

- Include the initial month’s premium payment
- 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

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("member", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

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 # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YYYY)
Address (Street, City, State, Zip Code)		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Rehire	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	Member/Employee Occupation:	Hours Worked Per Week:
Phone #	Email Address	CA Real Estate License #	Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Change in Plan <input type="checkbox"/> 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
<input type="checkbox"/> Supplemental/Optional Life ¹ and Accidental Death and Dismemberment (AD&D) <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$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.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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)



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:
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 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: _____	<input type="checkbox"/> Checking Account
Account Number: _____	<input type="checkbox"/> Savings Account
Authorized Signature	
_____ Signature of Authorized Signer on Above Bank Account <i>(As it appears in the financial institution's records)</i>	
Date: _____	

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.

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company (“MetLife”) or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB) a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.



Delaware American Life Insurance Company
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to: MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.