

METROPOLITAN LIFE INSURANCE COMPANY



One Madison Avenue
New York, NY 10010-3690

ENROLLMENT FORM FOR GROUP INSURANCE BENEFITS

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print) Loyola University New Orleans		Group Report No. 102476	Sub Division	Branch
Employer's Street Address		City	State	Zip Code
Employee Work Location				
Date of Hire (Mo./Day/Yr.) / /	Employee Annual Earnings \$	Employee's Occupation:	Coverage Effective Date (Mo./Day/Yr.): / /	
Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> On Layoff/Leave of Absence <input type="checkbox"/> Late Enrollee (Statement of Health Required)		Hours Worked Per Week:	<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Salaried	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Reason for Enrollment: <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Change in Coverage Amount Requested		<input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount		
Non-Medical Issue Amount for Life Benefits, if available:	Insurance Amount Not Requiring Medical Underwriting	Insurance Amount Requiring Medical Underwriting	Plan Maximum	
For Employee:	\$ _____	\$ _____	\$ _____	
For Dependents Spouse:	\$ _____	\$ _____	\$ _____	
Signature of Employer		Print Name	Date (Mo./Day/Yr.) / /	

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print)	First	Middle	Last	Social Security No.	Date of Birth (Mo./Day/Yr.) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	Street	City		State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
E-mail Address					Phone No.(include area code) () -	

COVERAGE REQUEST DATA: EMPLOYEE COVERAGES

I have received and read a copy of my employer's current announcement of the group plan.

I request the following coverages:

Basic Life/ AD&D 2 X Base Annual Earnings up to a maximum of \$250,000 (60% Employer Paid)

Long Term Disability (LTD) (Employer Paid)

Optional Life Check One: 1 X 2 X 3 X Base Annual Earnings up to a maximum of \$500,000

I wish to decline any coverage not checked above for which I may be eligible. For Life coverage, I understand that I will be required to submit evidence of my good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired

Voluntary Accidental Death & Dismemberment (VAD&D)

I understand my VAD&D benefit plan described in the announcement. I want to be covered under the group plan for which I am or may become eligible.

VAD&D Coverage Options: Employee Only Family Protection Plan Plus

VAD&D Multiple of Pay Plan Design: You may elect a multiple of pay of one to 10 times your annual earnings, not to exceed \$500,000.

Check One: 1X 2X 3X 4X 5X 6X 7X 8X 9X 10X

COVERAGE REQUEST DATA: DEPENDENT COVERAGES

I have received and read a copy of my employer's current announcement of the group plan.

I request the following coverages:

Basic Dependent Life Spouse Amount \$5,000 * Child(ren) Amount 14 days to 1 year \$1,500; 1 year and over \$5,000 *

Optional Dependent Life Spouse Only 50% of the Employees Optional Life Benefit amount up to a maximum benefit of \$50,000*

*Amounts will be subject to state limit requirements, if applicable.

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attach a separate sheet of paper, signed and dated)

Spouse:	_____	Date of Birth (Mo./Day/Yr.)	_____	Social Security No.	_____
Child(ren):	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

I wish to decline any coverage not checked above for which I may be eligible. For Dependent Life coverage, I understand that I will be required to submit evidence of my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired.

ENROLLMENT FORM FOR GROUP INSURANCE BENEFITS (Continued)

SECTION TO BE COMPLETED BY EMPLOYEE (Continued)

DESIGNATION OF BENEFICIARY FOR EMPLOYEE LIFE BENEFITS (The Dependent Life Benefits are Payable to the Employee)				
<input type="checkbox"/> I Designate as my Primary Beneficiary: <input type="checkbox"/> My Designation of Beneficiary is on a separate form which is signed, dated and attached.				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
TOTAL:				100%
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
TOTAL:				100%
Unless designated otherwise, payment will be made in equal shares or all to the survivor. I RESERVE the right to change this designation at any time.				
Employee Signature: _____			Date of Signature _____ (Mo./Day/Yr.)	

MEDICAL INFORMATION SECTION FOR CONTRIBUTORY LIFE BENEFITS

ALL PROPOSED INSUREDS MUST ANSWER THE FOLLOWING QUESTION:

	Employee	Spouse	Child(ren)
Hospitalization Question			
Have you been Hospitalized (as defined on page 3 of this form) during the 90 days preceding the date of this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to the above question, or you are a late enrollee, you must also complete and attach a Statement of Health form.

ENROLLMENT FORM FOR GROUP INSURANCE BENEFITS (Continued)
DECLARATION SECTION

TO BE COMPLETED BY THE EMPLOYEE AND OTHER PROPOSED INSURED(S) AGE 18 YEARS OR OLDER

Each Proposed Insured signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each Proposed Insured understands that this information will be used by MetLife to determine his or her insurability.

For the Employee Proposed Insured:

I declare that I am actively at work on the date of this enrollment form and, for any contributory life insurance only, I have been actively at work for at least 20 hours during the 7 calendar days preceding that date. I understand that if I am not so actively at work on the Effective Date of my contributory life insurance only, such insurance will not take effect until MetLife receives evidence of my good health satisfactory to MetLife. I also understand that if I have been Hospitalized (as defined below) during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of my good health satisfactory to MetLife.

For the Dependent Proposed Insured(s):

I understand that, on the date a dependent insurance benefit is scheduled to take effect, I must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If I do not meet this requirement on such date, my insurance will take effect on the date I am no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility; an intermediate care facility, or a long term care facility, or receipt of chemotherapy, radiation therapy, or Dialysis, wherever performed.

For the Accelerated Benefits Option

I understand that my Life Benefit includes an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. I also understand that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

For Benefit Increases Requested After Initial Enrollment Period Expires

I understand that if I have not elected the maximum life benefits for which I or my dependent(s) are eligible, I or my dependent(s) may be required to submit evidence of good health satisfactory to MetLife if I want to increase such benefits after my initial enrollment period has expired. I also understand that coverage will not take effect, or it will be limited, until I receive notice that MetLife has approved the benefit increase.

For Payroll Deduction Authorization By the Employee

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Signature(s): The employee must sign in all cases:

Employee Signature

Date (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature

Print Name

Date (Mo./Day/Yr.)

Other Signature

Print Name

Date (Mo./Day/Yr.)

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, or if you reside in one of the following states, note the following applicable warning:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

If you are applying for coverage under a self-funded plan or insurance under a policy issued in any state other than those listed above, or if you reside in any state other than those states listed above, note the following warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.