

## ENROLLMENT FORM FOR WASHINGTON UNIVERSITY POSTDOCTORAL APPOINTEES

### SECTION TO BE COMPLETED BY UNIVERSITY

Name of Employer (Please Print) <b>Washington University</b>		Group Report No. <b>109776</b>	Sub Division	Branch
Street Address One Brookings Dr., Box 1190		City St. Louis	State MO	Zip Code 63130
Date of Hire (Mo./Day/Yr.)	Base Annual Salary (BAS) \$	Occupation:	Coverage Effective Date (Mo./Day/Yr.):	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		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 Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Late Enrollee ( <b>Statement of Health Required</b> ) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____				

### SECTION TO BE COMPLETED BY APPOINTEE

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:

I have received and read a copy of the University's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.

I request the following coverage:

#### Appointee Coverage

- Optional Life (Select one coverage option. **Note:** Coverage amounts exceeding \$500,000 up to \$1,000,000 require a Statement of Health form)  
 1x     2x     3x     4x Base Annual Salary
- Optional AD&D

#### Dependent Spouse Coverage

- Dependent Spouse Life\* (Select one coverage option. **Note:** Coverage amounts exceeding \$50,000 require a Statement of Health form):  
 \$25,000     \$50,000     \$75,000     \$100,000
- Dependent Spouse AD&D

For Domestic Partner coverage, you must complete and attach a Domestic Partner Affidavit or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available. Check the applicable box:

- My Domestic Partner Affidavit is attached.  
 My Domestic Partner and I are registered as domestic partners or members of a civil union as stated above.

#### Dependent Child Coverage

- Dependent Child Life\* \$4,000 \_\_\_\_\_  
 Dependent Child AD&D

\*Amounts will be subject to state limits, if applicable.

<b>If applying for Dependent coverage (Spouse/Domestic Partner and Child), complete section below:</b> Number of dependents (including spouse/domestic partner) _____ Name (Last, First, MI) _____ Date of Birth _____ Sex _____ (M/F) Spouse/Domestic Partner: _____ Child(ren): _____ _____ _____ _____			If dependent children are full-time students in college, vocational or trade school, please complete the following: <table border="1"> <thead> <tr> <th>Child(ren)</th> <th>Name of School</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td></tr> </tbody> </table>	Child(ren)	Name of School	_____	_____	_____	_____	_____	_____	_____	_____
Child(ren)	Name of School												
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**DECLARATION SECTION**

Each person 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 person understands that this information will be used by MetLife to determine his or her insurability.

The appointee **declares** that he or she is actively at work on the date of this enrollment form. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is 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; intermediate care facility, or long term care facility, or receipt of the following treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

**For the Accelerated Benefits Option**

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. 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 Changes Requested After Initial Enrollment Period Expires**

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect 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.

**For Payroll Deduction Authorization By the Appointee**

I **authorize** the University 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.

**Fraud Warning:**

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the 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.

**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.

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**Kansas and 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.

In any other case, read 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.**

<b>BENEFICIARY DESIGNATION FOR APPOINTEE INSURANCE (Dependent Insurance is Payable to the Appointee)</b>			
The Appointee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Appointee understands that he or she has the right to change this designation at any time.			
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)

**Signature(s):** The appointee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date (Mo./Day/Yr.)

# PRIVACY NOTICE

If you submit a request for insurance (enrollment form, and if applicable, Statement of Health form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of each of these companies:

**Metropolitan Life Insurance Company**

**Paragon Life Insurance Company**

**Please read this Privacy Notice carefully.** It describes how we learn about you and how we treat that information. (If anyone else is proposed for insurance, what we say here also applies to information about them.)

**Why We Need Information:** We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies.

**How We Get Information:** What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- 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 your finances, employment, hobbies, mode of living, work history, and driving record.

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 Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (617) 426-3660, or by contacting MIB at [www.mib.com](http://www.mib.com).

**How We Protect What We Know:** We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

**How We Use and Disclose What We Know About You:** We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise, we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, to you.

**You Can See and Correct Your Information:** Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement in any future disclosure of Information.

**You Can Get Other Material from Us:** This is a general description of our information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, [www.metlife.com](http://www.metlife.com), or write to us at MetLife, c/o MetLife Privacy Office, P.O. Box 2006 Aurora, Illinois 60507-2006.