

Name of Employee	Last	First	Middle	Social Security No.	Date of Birth (Mo./Day/Yr.)	Gender
Employee's Address			Street	City	State	Zip Code
Date of Hire						
Name of Employer Cape Fear Community College						
Salary \$				Coverage Effective Date (Mo./Day/Yr.)		

I request the following coverage:

Voluntary Life Insurance (Employee-amount can not exceed 5 times Salary)

- | | |
|--|---|
| <input type="checkbox"/> \$20,000 monthly cost \$3.60 | <input type="checkbox"/> \$80,000 monthly cost \$14.40 |
| <input type="checkbox"/> \$30,000 monthly cost \$5.40 | <input type="checkbox"/> \$90,000 monthly cost \$16.20 |
| <input type="checkbox"/> \$40,000 monthly cost \$7.20 | <input type="checkbox"/> \$100,000 monthly cost \$18.00 |
| <input type="checkbox"/> \$50,000 monthly cost \$9.00 | <input type="checkbox"/> \$120,000 monthly cost \$21.60 |
| <input type="checkbox"/> \$60,000 monthly cost \$10.80 | <input type="checkbox"/> \$150,000 monthly cost \$27.00 |
| <input type="checkbox"/> \$70,000 monthly cost \$12.60 | <input type="checkbox"/> Other _____ |

Voluntary Life Insurance (Spouse-Employee must elect coverage / cannot exceed 50% of the Employee Election Amount)

- | | |
|---|---|
| <input type="checkbox"/> \$5,000 monthly cost \$0.90 | <input type="checkbox"/> \$20,000 monthly cost \$3.60 |
| <input type="checkbox"/> \$10,000 monthly cost \$1.80 | <input type="checkbox"/> \$25,000 monthly cost \$4.50 |
| <input type="checkbox"/> \$15,000 monthly cost \$2.70 | <input type="checkbox"/> Other _____ |

Voluntary Life Insurance (Child--Employee must elect coverage)

- Option 1 - \$2,500 monthly cost \$0.34
- Option 2 - \$5,000 monthly cost \$0.68
- Option 3 - \$7,500 monthly cost \$1.02
- Option 4 - \$10,000 monthly cost \$1.36

****Flat monthly rate regardless of number of children / not per child rate****

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee 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. The Employee 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)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

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.

The employee **declares** that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

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.

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.

All other states:

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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee 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 Signed