Accidental Death Insurance Enrollment Form

MetLife
Metropolitan Life Insurance Company
New York, NY

Group Customer: Collegiate Alumni Trust - Group Customer #156129 - Experience #158109

Your Enrollment Information

OLA

_____
Title (Dr. / Mr. / Mrs. / Ms), First Name, Middle Initial, Last Name

_____ _____
Mailing Address *Home Phone*

_____ _____
City *State* *Zip Code* *Work Phone*

_____ _____ _____
Social Security # *Email* *Cell Phone*

Birth Date _____ Gender _____ Occupation _____ Preferred Phone ❑ Home ❑ Work ❑ Cell
MM/DD/YY *M/F*

My eligibility status is *(check one)*: ❑ Alumnus/a ❑ Student ❑ Faculty/Staff Member ❑ Eligible Family Member
If Eligible Family Member *(check one)*: ❑ Spouse/Domestic Partner ❑ Parent ❑ Adult Child ❑ Adult Sibling

Sponsoring college, university, school, or alumni/ae association: _____

I have read the enclosed brochure and I request coverage for the benefits for which I am eligible. I understand that premium payments are required for the benefits I select below.

Accidental Death Insurance.* *(Refer to brochure for eligibility, insurance amounts, and coverage description.)*

Amount requested: $_____ (in $25,000 multiples)
(if age <65, maximum amount is $1 million; if age 65-69, maximum amount is $500,000; if age 70-74, maximum amount is $250,000)

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ADM

Beneficiary Information. 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 and I revoke any previous beneficiary designation. I understand I have the right to change this designation at any time.

❑Check if more space is needed for additional beneficiaries and attach a separate page. Include all beneficiary information and sign/date the page.

1. _____ % _____
Full Name *Social Security #* *Birthdate* *Relationship*

_____
Mailing Address *Phone*

2. _____ % _____
Full Name *Social Security #* *Birthdate* *Relationship*

_____
Mailing Address *Phone*

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. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
3. I have read the applicable Fraud Warning(s) provided with this enrollment form.

Signature of Member X_____ Print Name_____ Date Signed_____

GEF09-1
DEC

Collegiate Alumni Trust
EF-ST600-NW (08/14)

After completion, sign and date the form as indicated above.
Make a copy for your records and return to: Meyer and Associates ◆ 18 Washington Avenue ◆ Chatham, NJ 07928 ◆ AlumLifeInsurance.com

Fraud Warning(s): For residents of Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of Alaska, Arizona, California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina North Dakota, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Wisconsin, and Wyoming:** 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. **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **For residents of Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **For residents of Kentucky:** 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. **For residents of Maine, Tennessee, Virginia and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties. **For residents of Oklahoma:** WARNING: 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. **For residents of Oregon:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **For residents of Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **For residents of Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.