**AVERY DENNISON Ref #80542**

103782010101

# GROUP UNIVERSAL LIFE ENROLLMENT FORM

**EMPLOYEE NAME:**_____ **SS#:**____/____/____
Last First M.I.

**ADDRESS:**_____ **CITY:**_____ **STATE:**____ **ZIP:**____
No. Street

**SEX:** ❑ M ❑ F **BIRTH DATE:**____/____/____ **TITLE PREFERENCE:** ❑ MR. ❑ MRS. ❑ MS. **ANNUAL EARNINGS:**____
(MM/DD/YYYY)

**DAYTIME PHONE:**____ **HIRE DATE:**____/____/____

## REASON FOR ENROLLMENT

❑ New Enrollment ❑ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)____/____/____

## EMPLOYEE COVERAGE

Note: A reduction in coverage may result in an irreversible Modified Endowment Contract (MEC) status and unfavorable tax treatment of withdrawals and loans, depending on circumstances. If you are planning to reduce your GUL coverage and do not want your certificate to become a MEC, please call 1-800-528-1245 to find out whether this will result in unfavorable tax consequences.

**A.** Select the annual earnings multiple that you desire. Your choice is from 1 to 8 times your annual earnings to a maximum of $2,000,000.[1] Plan minimum is the greater of $10,000 or 1 times your annual earnings. (Indicate the total amount of coverage you wish. Coverage is rounded up to the next higher $10,000 increment if not an even $10,000.)

❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x ❑ 7x ❑ 8x Annual earnings

**B.** Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?..... ❑ Yes ❑ No

**C.** In addition to the coverage, I elect to contribute a monthly dollar amount to my Cash Fund: $____

## SPOUSE/DOMESTIC PARTNER COVERAGE

**A.** Select coverage in $10,000 increments between $10,000 and $200,000.[1,3]
I elect the following total amount of coverage for my Spouse/Domestic Partner[2]: $____

**B.** Has your Spouse/Domestic Partner[2] smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?..... ❑ Yes ❑ No

**C.** In addition to the coverage, I elect to contribute a monthly dollar amount for my Spouse/Domestic Partner's[2] cash fund. $____

**NAME:**____ **BIRTH DATE:**____/____/____ **SS#:**____/____/____
Last First M.I. (MM/DD/YYYY)

**SEX:** ❑ M ❑ F **TITLE PREFERENCE:** ❑ MR. ❑ MRS. ❑ MS. **DEPENDENT TYPE:** ❑ SPOUSE ❑ DOMESTIC PARTNER[2]

## CHILD(REN) COVERAGE

**A.** Check box of desired coverage:[3] ❑ $10,000

**NAME:**____ **BIRTH DATE:**____/____/____ **SS#:**____/____/____ **SEX:** ❑ M ❑ F
Last First M.I. (MM/DD/YYYY)

**NAME:**____ **BIRTH DATE:**____/____/____ **SS#:**____/____/____ **SEX:** ❑ M ❑ F
Last First M.I. (MM/DD/YYYY)

*If you have more than two children, include their information on a separate sheet.*

[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.

[2]Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3]Amounts will be subject to state limits, if applicable.

**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)*

## HEALTH INFORMATION

**If you are enrolling during the initial enrollment period and you are enrolling for up to 1 times your annual earnings not to exceed $150,000 in coverage, or up to $10,000 for your Spouse/Domestic Partner, you must complete the Hospitalization question. If you are enrolling during the initial enrollment period and if you are electing more than 1 times your annual earnings not to exceed $150,000 in coverage or if you are electing coverage for your Spouse/Domestic Partner that exceeds $10,000, you must answer all questions below and complete the enclosed Authorization Form.**

**If you are enrolling after your initial eligibility period; if you answered "Yes" to any of the questions below for you, your Spouse/Domestic Partner, or dependent children; if you are electing more than 3 times your annual earnings not to exceed $300,000 in new coverage; or if you are electing new coverage for your Spouse/Domestic Partner that exceeds $100,000, you must also complete a Statement of Health form for that individual. Mercer Voluntary Benefits will mail a Statement of Health form to the address listed on this enrollment form for your completion.**

**Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.**

Your height _____feet _____inches Spouse/Domestic Partner height _____feet _____inches
Your weight _____pounds Spouse/Domestic Partner weight _____pounds

| | Employee | Spouse/ Domestic Partner | Child |
|---|---|---|---|
| **1.** Have you had any application for life, accidental death and dismemberment or disability insurance, declined, postponed, withdrawn, rated, modified, or issued other than as applied for? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| **2.** Are you now receiving or applying for any disability benefits, including workers' compensation? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| **3.** Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **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. | | | |
| **4. For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **For CT residents, please answer the following question:** To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | ❑ Yes ❑ No | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **5.** Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | | | |
| a. cardiac or cardiovascular disorder? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| b. stroke or circulatory disorder? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| c. high blood pressure? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| d. cancer, Hodgkins disease, lymphoma or tumors? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| e. diabetes? | ❑ Yes ❑ No | ❑ Yes ❑ No | |
| f. asthma, COPD, emphysema or other lung disease? | ❑ Yes ❑ No | ❑ Yes ❑ No | |

**GEF09-1**
**HEA**
*(The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana;*
**GEF09-1**
**HEA** *applies to residents of Connecticut, North Dakota and Utah)*

**PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM.**

## 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.

**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.

**California:** 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.

**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.

**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.

**Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

**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.

**Maine, Tennessee 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.**

**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.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**New York: (only applies to Accident and Health Insurance): 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 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.**

**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.

**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.

**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.

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

**Pennsylvania and all other states:** 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.

**GEF09-1**
**FW**
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**GEF09-1**
**FW** *applies to residents of Connecticut, North Dakota and Utah)*

## BENEFICIARY DESIGNATION FOR 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. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page, include all beneficiary information, and sign/date the page.

| Full Name (First, Middle, Last) | Relationship | Social Security # | Date of Birth (MM/DD/YYYY) | Phone # | Address (Street, City, State, ZIP) | Share % |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| **Payment will be made in equal shares or all to the survivor unless otherwise indicated.** | | | | | **TOTAL:** | **100%** |

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

| Full Name (First, Middle, Last) | Relationship | Social Security # | Date of Birth (MM/DD/YYYY) | Phone # | Address (Street, City, State, ZIP) | Share % |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| **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, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 30 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, 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 treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. 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.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

**SIGN & DATE** X _____ _____ _____
Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

**SIGN & DATE** X _____ _____ _____
Signature of Owner if a person other than Employee | Print Name | Date Signed (MM/DD/YYYY)

**GEF09-1**
**DEC**
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**DEC** *applies to residents of Connecticut, North Dakota and Utah)*