VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM

Reynolds
Ref #10603 (EE) 10604 (EE + Dependents)

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

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

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

DAYTIME PHONE:_____ **HIRE DATE:**____/____/_____
(MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

REASON FOR ENROLLMENT

❑ New Enrollment

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

COVERAGE REQUEST

I request the following coverage option: ❑ Employee Only ❑ Employee and Dependent(s)

You may elect employee VAD&D in multiples of pay of 1 to 5 times your annual base pay, rounded to the next higher $10,000 amount, not to exceed $1,500,000.

Check One: ❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x Annual Base Pay

DEPENDENT INFORMATION

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

SPOUSE/DOMESTIC PARTNER NAME[1]**:**_____ ❑ M ❑ F
Last First M.I.

BIRTH DATE:_____/_____/_____
(MM/DD/YYYY)

List each unmarried dependent child.

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

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

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

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

❑ *Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.*

[1]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.

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)*

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM.

Mercer Voluntary Benefits
PO Box 9122, Des Moines, IA 50306-9122
1-800-652-9512 • Fax: 515-365-1520

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 is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. 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.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. 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)*