

FLSmidth Ref #10629

GROUP UNIVERSAL LIFE ENROLLMENT FORM 086085010101

| EMPLOYEE NAME: | | | | |
|--|--|------------------------------|-----------------------|-----------------------|
| Last | First | | M.I. | |
| ADDRESS: | | CITY: | STATE: | 71D· |
| No. Stree | rt | OII 1 | OTATE | L II |
| | | | | |
| SEX: DMDF BIRTH DATE:(N | //TITLE F //M/DD/YYYY) | PREFERENCE: MR. MRS. | ☐ MS. BASE PAY: | |
| | , | | | |
| DAYTIME PHONE: | EMPLOYEE ID: | PAYROLL CENT | TER: | HIRE DATE: |
| | | | | |
| REASON FOR ENROLLMEN | Т | | | |
| □ Nove Hiro First Time Fligible | | | | |
| ☐ New Hire First Time Eligible | If due to a Qualifying Ev | cent enter event date (MAAA) | /DD /VVVV) / | , |
| ☐ Change in Enrollment | if due to a Qualifying Ev | vent, enter event date (MM) | /DD/ f f f f]/ | |
| | | | | |
| EMPLOYEE COVERAGE | | | | |
| Note: A reduction in coverage m | nay result in an irreversible | Modified Endowment Cont | ract (MEC) status an | d unfavorable tax |
| treatment of withdrawals and loc | | | | |
| not want your certificate to beco- consequences. | me a MEC, please call 1-a | 800-378-3090 to tind out w | nemer mis will result | in untavorable tax |
| A C-11 := \$10,000 : | | 00 \$2 000 000 1. | | |
| A. Select coverage in \$10,000 in maximum coverage amount of | | JU and \$2,000,000, not to | exceed | |
| I elect the following total amo | , , , , | | \$ | |
| B. In addition to the coverage, I | elect to contribute a month | ly dollar amount to my Cas | h Fund: \$ | |
| • | | , | | |
| SPOUSE COVERAGE | | | | |
| | ф10.0 | 00 | | |
| A. Select coverage in \$10,000 in lelect the following total amo | | | \$ | |
| B. In addition to the coverage, I | , , | | · —— | |
| Cash Fund. | elect to commodic a morni | ny donar amount for my spe | \$ | |
| | | | | |
| NAME: Last Fir | | M.I. BIRTH DATE: (MI | //_ SS#: | / / |
| | si B ence: 🖬 Mr. 🗖 Mrs. 🗖 Ms | , | VI/DD/ 1 1 1 1) | |
| OLA SW ST THEETHEREIN | ENOE: SWITE SWITE: SWITE | o. | | |
| | | | | |
| CHILD(REN) COVERAGE | | | | |
| | | | | |
| A. Check box of desired coverage | ge: ³ 🗖 \$5,000 🗖 \$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 childr | en, include their informatic | on on a separate sheet. | | |
| ¹ Life Insurance may include an Accelerated Be charge may be deducted from the accelerate | | | | |

ELIGIBILITY INFORMATION

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

If you and/or your dependents are enrolling after your initial eligibility period; if you are electing more than 2 times your base pay or \$400,000 in new coverage; or if you are electing new coverage for your spouse that exceeds \$10,000, 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 application for your completion.

GEF02-1

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

ADM applies to residents of Connecticut, North Dakota and Utah)

to seek assistance from a personal tax advisor.

² Spouse 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.

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

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.

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 Benefits): 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

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

| form. With such designation a I understand I have the right to upon the death of a Dependen | n(s) as primary ber iny previous design change this desigr t is payable to the | ation of a beneficiary for su nation at any time. I also ur Employee. | payable upon my death ich coverage is hereby re iderstand that unless othe | n for the MetLife insura evoked. erwise specified in the | nce coverage applied for in this group insurance certificate, insuration, 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: | | | | | | | |
| If all the primary benef | iciary(ies) die k | pefore me, I designate | e as contingent ber | neficiary(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: | | | | | | | |

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 my 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.
- 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

| 7.1 have read the applicable fraud vvalining(s) provided in this enformer form. | | | | | | |
|---|------------|--------------------------|--|--|--|--|
| SIGN X Signature of Employee | | | | | | |
| Signature of Employee | Print Name | Date Signed (MM/DD/YYYY) | | | | |
| SIGN | | | | | | |
| Signature of Owner if a person other than Employee | Print Name | Date Signed (MM/DD/YYYY) | | | | |
| GEF09-1 | | | | | | |

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Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.