

GROUP SPECIFIED DISEASE ENROLLMENT FORM

For **CSEA** Inc.

–Group Report No. 0147997

MetLife

Metropolitan Life Insurance Company, New York, NY

MEMBER INFORMATION

Name (print)	First	Middle	Last	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Mo./Day/Yr.)
Address	Street	City	State	Zip Code	Daytime Phone Number (include area code)
E-mail Address					Social Security Number

If requesting Dependent coverage (Spouse, Domestic Partner* and Child), complete section below:

	Name (Last, First, MI)	Date of Birth	Sex (M/F)	Social Security No.
Domestic Partner/ Spouse:	_____	_____	_____	_____
Child(ren):	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

*Additional information is required for Domestic Coverage. Please contact Pearl Carroll & Associates at 1-877-847-2732

COVERAGE REQUEST DATA:

I have received and read a copy of the disclosure document for Initial Coverage. I would like to apply for **\$15,000** benefit for myself, **\$15,000** benefit for my Spouse/Domestic Partner (if shown above) and **\$10,000** for each of my Dependent Child(ren) (if shown above). I understand that no person will be covered until they are accepted for coverage by MetLife and initial premium is received. I also understand that my Spouse/Domestic Partner and Dependent Child(ren) are not eligible for coverage if I am not approved for coverage.



For all persons to be insured is there coverage in force that provides benefits for at least major medical, or at least basic hospital and basic medical?

Member	Spouse/Domestic Partner	Child(ren)
<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No



Do you, your spouse or dependent children currently have coverage under, or currently have an application pending for, any other critical illness or specified disease policy?

Member	Spouse/Domestic Partner	Child(ren)
<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No

If yes, please list who is covered and the conditions covered under the other policy(ies).

MEDICAL INFORMATION:

Please complete question(s) below.



Have you EVER had any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; or (vi) an organ transplant (or been on the list for an organ transplant)?

Member	Spouse/Domestic Partner	Child(ren)
<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No	<input type="checkbox"/> YES <input type="checkbox"/> No

PLEASE SIGN PAGE 2 AND RETAIN A COPY OF THE FULLY COMPLETED FORM FOR YOUR RECORDS; RETURN ORIGINAL TO:

Pearl Carroll & Associates
12 Cornell Rd, Latham NY 12110

IF YOU HAVE ANY QUESTIONS, CALL PEARL CARROLL & ASSOCIATES AT 1-877-847-2732



DECLARATION SECTION

The member declares that he or she is actively at work on the date of this enrollment form. In addition if the member is not actively at work on the scheduled Effective Date of the insurance requested, such insurance will not take effect until the member returns to active work.

MetLife does not charge premium on account of any person during time periods when such person is not insured.

For Payroll Deduction Authorization By the Member

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.

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: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each 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.

Oregon and 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.

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.

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.

Signature(s): The member must sign in all cases. 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. Each person understands that this information will be used by MetLife to determine his or her insurability. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Member Signature

Print Name

Date (Mo./Day/Yr.)

Other Proposed Insured Signature

Print Name

Date (Mo./Day/Yr.)

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