



Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM FOR GROUP DISABILITY INCOME INSURANCE

GROUP CUSTOMER INFORMATION (To be Completed by the Member/Employee)

Name of Policyholder: Pennsylvania Institute of Certified Public Accountants		Group Customer # 226940
<input type="checkbox"/> Member of Pennsylvania Institute of CPAs	Date of Membership (MM/DD/YYYY)	Member ID #
<input type="checkbox"/> Employee of a Member of PICPA	Date of Hire (MM/DD/YYYY)	Name of Member Firm
Member Firm Address (Street, City, State, Zip Code)		
<input type="checkbox"/> Employee of PICPA	Date of Hire (MM/DD/YYYY)	

YOUR ENROLLMENT INFORMATION (To be Completed by the Member/Employee)

Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)	Phone #	Date of Birth (MM/DD/YYYY)	
Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment	Date of Membership (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 may be required for the benefits I select below.

- ▶ You must complete a Statement of Health form:
- If you are enrolling for over 270 days of becoming a member of the Policyholder.
 - If enrolling over 270 days of establishing your own practice for the first time.
 - If he or she is an employee, and the coverage is provided on a contributory basis, and you are enrolling over 270 days following the dates he or she first becomes eligible.
 - If he or she is an employee, and the coverage is provided on a non-contributory basis, and you are enrolling over 270 days of the end of the employer's eligibility waiting period; provided that you are under Age 60 at the time of application.

Disability Income Insurance

Long Term Disability

Select your monthly benefit:

Enter a monthly benefit in multiples of \$100, with a minimum \$500 and a maximum of \$2,000 for members/employees under age 60 \$ _____

Waiting period: 90 days

Benefit Period: 5 years

**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 North Dakota and Utah)

SUBMISSION INSTRUCTIONS

After completion, sign and date the form on the last page where indicated. Make a copy for your records and return to Gallagher Affinity, P.O. Box 4111, Clinton, IA 52733

FRAUD WARNINGS

Before signing this Statement of Health 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

*(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 North Dakota and Utah)

DECLARATIONS AND SIGNATURES

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 understand that if I do not enroll for disability coverage during the 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 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.
4. If applicable, 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.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.



_____	_____	_____
Signature of Member/Employee	Print Name	Date Signed (MM/DD/YYYY)

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

SUBMISSION INSTRUCTIONS

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