MetLife
Voluntary Accidental Death and Dismemberment Insurance

Employee Name: _____
Last Name First Name MI

Date of Birth: Mo. Day Year S.S.#: / /

Employer: Michigan Technological University

Employee Primary Beneficiary — Give Full Name and Relationship to Employee

First Name Initial Last Name Relationship

Employee Contingent Beneficiary — Give Full Name and Relationship to Employee

First Name Initial Last Name Relationship

Policy Number: 104753-1-G

Please Select Plan and Amount of Insurance:

☐ PLAN I (Employee Only) ☐ PLAN II (Family Plan) Amount of Insurance: $

☐ REQUEST TO PARTICIPATE

I hereby request to participate in the Group Insurance Program and agree to contribute premium in the appropriate manner.

☐ WAIVER OF INSURANCE

I do not want to participate in the Group Insurance Program offered through my employer, and I understand that evidence of insurability satisfactory to the Insurance Company may be required if I desire to participate in the plan at a later date.

This enrollment card supersedes any previous enrollment card which may have been submitted for the above benefit.

Signed: _____ Date: _____

RETURN THIS ENROLLMENT CARD TO YOUR HUMAN RESOURCES OFFICE

RESET FORM

03-23-07