

ENROLLMENT FORM FOR AFFILIATED TEAMSTERS HEALTH AND WELFARE FUND OF MARYLAND SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer Affiliated Teamsters Health and Welfare Fund of Maryland		Group Customer # 137752	Report #	Sub Division	Branch
Employer's Street Address 9411 Philadelphia Road, Suite S		City Baltimore	State MD	Zip Code 21237	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) \$	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		Hours Worked Per Week		<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Salaried	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire/First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required)					

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security #	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address Street City State Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
E-mail Address		Phone No. (include area code)	
<p>COVERAGE REQUEST DATA:</p> <p>I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.</p> <p>I request the following coverage:</p> <p>Employee Coverage</p> <p><input checked="" type="checkbox"/> Basic Life (Employer Paid)</p> <p><input checked="" type="checkbox"/> Basic Accidental Death & Dismemberment (AD&D) (Employer Paid)</p>			

**GEF02-1
ADM**

DECLARATION SECTION

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. The employee **declares** that he or she is actively at work on the date of this enrollment form.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

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.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

**GEF02-1a
DEC**

**Please Retain A Copy of The Fully-Completed Form For Your
Records And Return The Original To Your Employer**

(Continued on Following Page)

1 Affiliated Teamsters Health and Welfare Fund of Maryland (05/09)

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE				
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.				
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.



Employee Signature

Print Name

Date Signed (Mo./Day/Yr.)