



Metropolitan Life Insurance Company, New York, NY
 Small Market Administration
 P.O. Box 14593, Lexington, KY 40512-4593
 Fax: 1-888-505-7446

ENROLLMENT FORM FOR GROUP INSURANCE
SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Name of Employee Last First Middle			Social Security No.		Date of Birth (Mo./Day/Yr.)		<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Street Address			City	State	Zip Code	Marital <input type="checkbox"/> Single <input type="checkbox"/> Married Status: <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Name of Employer Green County			Date of Hire (Mo./Day/Yr.)		Coverage Effective Date (Mo./Day/Yr.) 1/1/2021		
Work Status: <input type="checkbox"/> New Hire <input checked="" type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence							
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____							
Reason for Enrollment: <input checked="" type="checkbox"/> New Coverage <input type="checkbox"/> New Hire / First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____							

COVERAGE REQUEST DATA:

The enrollment form is accompanied by the plan summary materials providing details of the group plan(s) (the "Plan Summary"). I have received and read the Plan Summary. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage(s):

Employee Coverage

Dental Dual Option (Select one plan and one option):

Plan A:

- Employee Only Cost Per Month \$ 33.68
- Employee & Spouse Only Cost Per Month \$ 74.20
- Employee & Child(ren) Only Cost Per Month \$ 84.44
- Employee, Spouse, & Child(ren) Cost Per Month \$ 114.44

*Cost may vary slightly due to rounding

Plan B:

- Employee Only Cost Per Month \$ 29.69
- Employee & Spouse Only Cost Per Month \$ 65.40
- Employee & Child(ren) Only Cost Per Month \$ 74.43
- Employee, Spouse, & Child(ren) Cost Per Month \$ 100.87

*Cost may vary slightly due to rounding

Vision (Select one option):

- Employee Only Cost Per Month \$ 6.63
- Employee & Spouse Only Cost Per Month \$ 12.34
- Employee & Child(ren) Only Cost Per Month \$ 12.34
- Employee, Spouse, & Child(ren) Cost Per Month \$ 18.73

*Cost may vary slightly due to rounding

I wish to **DECLINE** any coverage not checked above for which I may be eligible For Dental and/or Dependent Dental coverage, a waiting period may be required before I can enroll. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

