

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)			
Name of Policyholder: Insurance and Benefits Trust of the Peace Officers Research Association of California (PORAC)		Sponsoring/Participating Association (if different from Policyholder)	Group Customer # 233040
YOUR ENROLLMENT INFORMATION (To be Completed by the Member)			
Name (First, Middle, Last)		Social Security # - -	
Address (Street, City, State, Zip Code)		Phone #	Date of Birth (MM/DD/YYYY)
<input type="checkbox"/> New Enrollment	Date of Hire (MM/DD/YYYY)	Date of Membership (MM/DD/YYYY)	Hours Worked Per Week:
<input type="checkbox"/> Change in Enrollment			
Email Address			
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 or may not be required for Basic Life and Basic AD&D. Please reference your certificate for details.			
Term Life Insurance			
<input checked="" type="checkbox"/> Basic Life			
Accidental Death & Dismemberment (AD&D) Insurance			
<input checked="" type="checkbox"/> Basic AD&D			

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 Connecticut, North Dakota and Utah)

FRAUD WARNINGS

Before signing this enrollment 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.

GEF09-1a

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SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.**
Make a copy for your records and return to your plan administrator.

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.

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BENEFICIARY DESIGNATION FOR MEMBER INSURANCE				
I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.				
I understand I have the right to change this designation at any time.				
<input type="checkbox"/> Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

DECLARATIONS AND SIGNATURE		
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 able to perform the normal activities required to be covered under the plan on the date I am enrolling. I declare that on the date of insurance I am not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or Hospitalized. I understand that if I do not meet these requirements on such date, my insurance will take effect on the date I am no longer confined, receiving or applying to received disability benefits, or Hospitalized. Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
3. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.		
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.		
	<div style="border: 1px solid black; padding: 5px;"> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Signature of Employee Print Name Date Signed (MM/DD/YYYY) </div> </div>	

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