Group Universal Life (GUL) Program Change Form

Metropolitan Life Insurance Company, New York, NY

Group Name **Wright State University** ________ GUL# ________

Work Location (City, State, Zip) ________

Employee Social Security # ________ Daytime/Work Phone # ________

Last Name ________ First ________ M.I. ____ Date of Birth ________

Street Address ________ Apt.# ________

City ________ State ________ Zip Code ________

☐ Please check box if the information above represents a change of address.

1 **CHANGE OF PLAN:** (change of current program option)

☐ From: Group Term Life (28216) To: Group Universal Life (GUL) (28217)
☐ From: Group Universal Life (GUL) (28217) To: Group Term Life*(28216)

* If applicable, you will automatically receive a check for the full cash surrender value of your Group Universal Life certificate.

X________ Date ________
Signature of Employee, or Owner if Coverage was Assigned

2 **EMPLOYEE COVERAGE:** ☐ Cancel Coverage ***or*** (☐ Increase* ☐ Decrease) the face amount of insurance.

☐ 1x ☐ 2x ☐ 3x Annual Earnings $ ________ = ________
(Round new face amount to next higher $1,000 if not already an even multiple) New Face Amount

Previous Monthly Employee Premium $________ **New Monthly Employee Premium** $________
(call **1-800-523-2894** toll-free to verify premium)

Automatic Salary Increases: ☐ Yes** ☐ No

* If you are increasing your coverage amount, include proof of your family status change within 31 days of the event, or complete Sections 6 and 7 on the following page.
** If you previously elected to discontinue automatic salary increases, and now wish to reactivate this feature, complete and submit a Statement of Health form along with this change form.

X________ Date ________
Signature of Employee, or Owner if Coverage was Assigned

3.

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?	**Employee** ☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

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.

MEDICAL INFORMATION: Complete all questions below if: (a) you are increasing your employee coverage amount up to $300,000.

Your coverage will be limited to the non-medical issue amount until you receive notice that MetLife has approved your request for greater amounts of coverage.

MetLife will review your answers to the questions and any additional information you provide regarding the health status of the person for whom coverage is being requested, as of the date MetLife receives the completed Change Form. Any decision to issue coverage will not take into account any material change in the health status of the person for whom coverage is being requested which occurs after the date we receive this Change Form.

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Medical Information - For Employee Life Insurance Amounts in Excess of $200,000, Answer The Following Questions.

lease complete all questions below. Omitted information will cause delays. In the Medical Information section, "you" and "your" refers to the person for whom insurance is requested.

	Employee
1. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:	
a. chest pain or heart trouble?	☐Yes ☐No
b. high blood pressure, stroke or circulatory disorder?	☐Yes ☐No
c. cancer or tumors?	☐Yes ☐No
d. anemia, leukemia or other blood disorder?	☐Yes ☐No
2. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐Yes ☐No
3. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐Yes ☐No
4. Are you now receiving or applying for any disability benefits including workers' compensation?	☐Yes ☐No

If you answered "Yes" to any of the above questions, you must also complete and attach a Statement of Health form.

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4. DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial 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.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

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.

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.

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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.) ____________

If you have any questions, please contact one of our Customer Service Representatives toll-free at

1-800-523-2894

Please send this completed form to:
MetLife
Group Life Products
P.O. Box 2006
Aurora, IL 60507-2006