

INSTRUCTIONS

Thank you for downloading the MetLife Term Life Insurance Enrollment Kit. Our enrollment assisters are available to help. If you have questions simply call plan administrator *Member Benefits* at 1-800-282-8626.

1. Complete the MetLife Enrollment Form.

2. Complete the MetLife Authorization Form.

3. Complete the Payment Method/ABN Membership Form.

Payment Option 1: Monthly Auto-pay

If you elect to pay by Monthly Bank Draft (ACH), you do not need to send any premium. Upon approval of your application, we will automatically draft your account on a monthly basis. Make sure to complete the Authorization section and include a VOIDED check.

Payment Option 2: Direct Annual Billing

If you elect the Direct Annual Billing method, upon approval of your application, you will receive an initial invoice for the amount of premium due to pay your coverage through the end of the calendar year (to December 31st.) You will receive annual invoices thereafter, which will be due on January 1st.

4. Submit your completed Enrollment Kit.

Review your answers carefully for accuracy. Incomplete applications cannot be accepted. Illegible print may delay processing of application. When finished, please retain a copy of the enrollment form for your records.

Using this page as a cover sheet, submit your completed kit using one of these methods:

Option 1: Fax to 904-212-2058

Option 2: Email to support@memberbenefits.com

Option 3: Mail to the plan administrator: Member Benefits
10739 Deerwood Park Blvd, Suite 200B
Jacksonville, FL 32256

Applicant name:	
Today's date:	

ENROLLMENT FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)	
Name of Policyholder: American Association of Business Networking	Group Customer # 5343606

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)		
Name (First, Middle, Last)	Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Email Address	Phone #	<input type="checkbox"/> New Enrollment

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 are required for the benefits I select below.

Term Life Insurance
<input type="checkbox"/> Term Life ¹ Enter a multiple of \$25,000 \$ _____ up to \$250,000 (under age 40), \$150,000 (up to age 49) or \$100,000 (age 50-59)
<input type="checkbox"/> Dependent Spouse/Domestic Partner ² Life ^{1,3} Enter a multiple of \$25,000 \$ _____ up to \$100,000 (up to age 49) or \$50,000 (age 50-59), maximum not to exceed 50% of Term Life.
<input type="checkbox"/> Dependent Child Life ³ \$5,000

Accidental Death & Dismemberment (AD&D) Insurance
<input type="checkbox"/> Voluntary AD&D First select your option <input type="checkbox"/> Member Only <input type="checkbox"/> Member + Spouse/Domestic Partner ² <input type="checkbox"/> Member + Child(ren) <input type="checkbox"/> Member + Spouse/Domestic Partner ² + Child(ren)
Then select your level of coverage Enter a multiple of \$25,000 up to a maximum of \$1,000,000. \$ _____

Dependent Information		
If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:		
Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.		

¹ 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. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

² Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

³ Amounts will be subject to state limits, if applicable.

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)

After completion, sign and date the form on the last page where indicated. Make a copy for your records and return to:
 MetLife Statement of Health, PO Box 14069, Lexington, KY 40512 or EMAIL: SOHsubmissions@metlife.com

Smoking Status Information			
Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 2 years?	Member <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse/Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you are changing smoking status: Status is changing from: <input type="checkbox"/> Smoker to Non-Smoker <input type="checkbox"/> Non-Smoker to Smoker Change is for: <input type="checkbox"/> Member <input type="checkbox"/> Spouse/Domestic Partner			

GEF02-1
ADM
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GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, “you” and “your” refers to the person for whom insurance is being requested.

Your height _____ feet _____ inches	Spouse/Domestic Partner height _____ feet _____ inches	
Your weight _____ pounds	Spouse/Domestic Partner weight _____ pounds	

- | | Member | | Spouse/Domestic Partner |
|--|--|--|--|
| 1. 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are you now receiving or applying for any disability benefits, including workers' compensation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days?
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. | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. For residents of all states except CT, please answer the following question: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?
For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | | | |
| a. cardiac or cardiovascular disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. stroke or circulatory disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. high blood pressure? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. cancer, Hodgkin's disease, lymphoma or tumors? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered “yes” to any of the above questions, a Statement of Health form must also be completed for the person to whom the “yes” applies.

GEF09-1
HEA
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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.

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 to the extent required by applicable law.

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.

GEF09-1
FW
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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.

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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FW

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GEF09-1

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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.


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, including any medical information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
3. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for 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.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.



Signature of Member
Print Name
Date Signed (MM/DD/YYYY)

GEF09-1

DEC

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Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and/or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and/or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.



_____ Signature of Member	_____ Date Signed (MM/DD/YYYY)
_____ Print Name	_____ State of Birth
_____ Country of Birth	



_____ Signature of Spouse/Domestic Partner	_____ Date Signed (MM/DD/YYYY)
_____ Print Name	_____ State of Birth
_____ Country of Birth	

PLEASE SELECT A PAYMENT METHOD:

OPTION 1 (Monthly Auto-pay): I wish to use Monthly Auto-pay. I have included a VOID check and completed the Authorization below.

I hereby authorize Member Benefits (MB) to initiate debit entries and to initiate, if necessary, credit entries as adjustments for any debit entries in error to my Checking account and the Financial Institution named below to debit and/or credit the same account. MB will not be held responsible for a policy lapse or cancellation due to nonpayment if withdrawal is prepared and not honored for any reason and amount due is not paid. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law and that MB and the Financial Institution may discontinue this service.

This authority is to remain in full force and effective until MB and the Financial Institution have received written notice from me of its termination in such time and manner as to afford MB and the Financial Institution a reasonable opportunity to act on it. Note: If the ACH debit is returned for non-sufficient funds, a \$25 nonrefundable service fee will be applied when allowed by law.

Payor Name (as it appears on Account)	Name of Financial Institution

ATTACH VOID CHECK HERE

OPTION 2 (Direct Annual Billing): Please bill me annually. By selecting this method, if you are approved for coverage, you will receive your certificate of insurance and an initial invoice for the required premium to pay your coverage and ABN membership dues up through the end of the plan year (Dec. 31st). Thereafter, you will be billed on a calendar annual basis.

ABN MEMBERSHIP AGREEMENT:

I hereby enroll for membership in the AMERICAN ASSOCIATION OF BUSINESS NETWORKING (ABN). Upon completion of this enrollment form and payment of initial dues (\$2.00 monthly), I understand that: (a) I will be entitled to ABN's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Metropolitan Life Insurance Company Enrollment Form for Insurance to ABN.

PLEASE SIGN AND DATE:

Signature of Member	Date
X	

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company (“MetLife”) or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB’s file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB’s information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.