



SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer Pinnacle PEO Corporation	Group Customer Number 05343663	Division	Class	Dept Code
Date of hire (mm/dd/yyyy)		Coverage Effective Date (mm/dd/yyyy)		
Original COBRA Effective Date (if applicable, mm/dd/yyyy)		COBRA Termination Date (if applicable, mm/dd/yyyy)		

SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name	Middle Name	Last Name		
SSN	Date of birth (mm/dd/yyyy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Address	City	State	ZIP	
Job title	Basic Annual Earnings \$	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Hours worked per week	

New Enrollment Change in Enrollment COBRA Continuation
If due to a Qualifying Event, enter date (mm/dd/yyyy)

- ▶ If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for Supplemental/Optional Life (Buy Up), Supplemental/Optional Dependent Spouse/Domestic Partner Life or Supplemental/Optional Dependent Child Life (Buy Up).
Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?
Employee: Yes No Spouse/Domestic Partner: Yes No Child(ren): Yes No
If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **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.
- ▶ The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**
- ▶ If you are enrolling after the initial enrollment period, please refer to the Declarations and Signature section of this enrollment form to determine the evidence of insurability and late entrant requirements. If evidence of insurability is required for a coverage you are electing, you must complete a Statement of Health form for all amounts you are requesting.

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

- Supplemental/Optional Life¹ and AD&D
Enter amount requested \$ _____
- Supplemental/Optional Dependent Spouse/Domestic Partner² Life^{1,3} and AD&D (Buy up)
Enter amount requested \$ _____
- Supplemental/Optional Dependent Child Life³ and AD&D (Buy up)
Enter amount requested \$ _____

- 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.

SECTION 3: 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.

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.

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)

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 Benefits*): 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.

GEF09-1

FW

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

GEF09-1

FW

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

SECTION 4: Beneficiary Designation for Employee 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. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (<i>first, middle, last</i>)	SSN	Date of birth (<i>mm/dd/yyyy</i>)		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name (<i>first, middle, last</i>)	SSN	Date of birth (<i>mm/dd/yyyy</i>)		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name (<i>first, middle, last</i>)	SSN	Date of birth (<i>mm/dd/yyyy</i>)		Relationship	Share %
Address	City	State	ZIP	Phone number	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (<i>first, middle, last</i>)	SSN	Date of birth (<i>mm/dd/yyyy</i>)		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name (<i>first, middle, last</i>)	SSN	Date of birth (<i>mm/dd/yyyy</i>)		Relationship	Share %
Address	City	State	ZIP	Phone number	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%

SECTION 5: Declarations and Signature

By signing below, I acknowledge:

- 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 on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.

**GEF09-1
DEC**

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF09-1

DEC applies to residents of Connecticut, North Dakota and Utah)



3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or 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. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here	Signature of Employee	Date signed (<i>mm/dd/yyyy</i>)
Print First Name	Print Middle Name	Print Last Name

**GEF09-1
DEC**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1
DEC** *applies to residents of Connecticut, North Dakota and Utah)*

How to submit this form

After completion, make a copy for your records and return the original to your employer.

(Form can't be modified once you click on this button.)

**GEF09-1
DEC**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1
DEC** *applies to residents of Connecticut, North Dakota and Utah)*