



**ENROLLMENT FORM FOR EMPLOYEE AND DEPENDENT  
LIFE, ACCIDENTAL DEATH & DISMEMBERMENT, and  
LONG TERM DISABILITY  
General Synod of the Associate Reformed Presbyterian Church**

Please Use Ink or Type      GROUP POLICY NUMBER: TM05585382 0001

**A. Employee Information**

Church or Agency of Employment: (Please Print)      County      State

Social Security Number      Last Name      First Name      MI      Date of Birth

Male       Married  Divorced      Home Phone      Work Phone      Email Address  
 Female       Single       Widowed      (   )      (   )

Street Address or Post Office Box      City      State      Zip Code

**B. Dependent Information:** (All Dependents 6 months and older have \$2,000 Term Life. Please list, if appropriate, your Spouse and Dependent Children)

Name of Spouse or Dependent (Last, First, MI)	Relationship	Date of Birth

**C. Beneficiary Information for Employee Insurance (Dependent Insurance is Payable to the Employee).** The Employee signing below names the following person(s) as primary beneficiary (ies) for any payment upon his or her death. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary (ies) Full Name (Last, First, MI)	Relationship	Date of Birth	Address (If Different from Above)

Contingency Beneficiary (ies) Full Name (Last, First, MI)	Relationship	Date of Birth	Address (If Different from Above)

**D. Declaration Section:** Each person signing below declares that all the information given in this enrollment form 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 eligibility.

**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 AD&D and Disability): 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

