



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

Please Use Ink or Type GROUP POLICY NUMBER: TM05585382 0001

A. Employee Information

Church or Agency of Employment: (Please Print)		State	
Social Security Number	Last Name	First Name	MI
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
Street Address or Post Office Box		City	State Zip Code

B. Dependent Information: (Spouse - \$5,000; Child More than 6 months old 0 \$2,500; Child 15 days to 6 months - \$200). 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:**

