



Enrollment Form – Medical, Dental, Vision, Life, AD&D, LTD Coverages

Please complete and return this form to your HR Administrator. Please remember to **sign on page three**.

Please enter your personal information.

Policyholder/Employer Name: _____

Employee Last Name/Surname: _____ First Name: _____ MI: _____

Date of Birth: _____ Assignment Effective Date: _____ Gender: ___ Male ___ Female

Classification/Job Title: _____ Email Address: _____

Country of Citizenship: _____ *If US Citizen, Include State:* _____

Social Security Number (SSN)/Individual Tax Identification Number (ITIN): _____

Assignment Country: _____ Assignment City: _____

Work Phone: _____ Annual Salary (USD) _____

I work: ___ Full-time ___ Part-time | Hours worked per week _____

Please enter your mailing address.

Address: _____ City: _____

State / Province: _____ Country: _____ Zip / Postal Code: _____

Please select who you are enrolling in this plan by placing an "X" in the corresponding box.

___ Self Only ___ Self + 1 ___ Self + 2 or More

Please select the coverages you would like to elect by placing an "X" in the corresponding box.

___ Medical ___ Dental ___ Vision

___ Basic Life ___ Accidental Death & Disability (AD&D) ___ Long-Term Disability



Please enter dependent information if you are enrolling dependents.

<i>Name</i>	<i>Relationship</i>	<i>SSN/ITIN</i>	<i>Date of Birth</i>
		___ N/A	
		___ N/A	
		___ N/A	
		___ N/A	
		___ N/A	
		___ N/A	

Please enter beneficiary information if you are electing Life and/or AD&D coverages.

<i>Beneficiary Name</i>	<i>Relationship</i>	<i>% of Benefit</i>

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy 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.

Kentucky: Any person who knowingly and with the 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.

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.



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.

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.

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.

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.

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.

AUTHORIZATION TO RELEASE, OBTAIN AND PROCESS PERSONAL INFORMATION

By signing below, I expressly provide my authorization for all my personal, sensitive (such as health information), location and financial information provided in this form, or obtained directly or indirectly from me or my employer during the underwriting process ("Personal Information"), to be reviewed and processed by and shared among Delaware American Life Insurance Company ("DelAm") and/or its affiliates and/or agents. Such Personal Information will be used for the following purposes: enrollment; underwriting; processing, administering, evaluating and adjudicating claims; utilization review; financial audit; servicing and providing insurance benefits; answering questions/requests; and complying with local and foreign legal obligations.

If applicable, I understand that I may exercise my rights to access, rectify, delete or object to the processing of my Personal Information by sending a written communication to admin.metlifeexpat@alico.com (please identify employer and group policy number in written request).

This authorization includes any transfer of Personal Information for the purposes described above from outside the US, including the European Economic Area and other jurisdictions with similar data privacy regimes, into the US or other jurisdictions that may not be considered to have an adequate level of data protection by the countries from where the Personal Information is sent.

To the best of my knowledge and belief, the information I provided in this enrollment form is true, complete, and correct. By my signature below, I agree that I am making this authorization on behalf of not only myself, but also as the agent or representative of any covered dependents or beneficiaries included in this form. This consent shall remain valid and effective and may be relied upon by DelAm, its affiliates, and agents, until revoked by sending a written communication to admin.metlifeexpat@alico.com.

I have read the applicable **Fraud Warning(s)** provided in this form. **New York Residents:** 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee Signature: _____

Date: _____