

Completed forms need to be sent to the DCA Admin Ofc for processing



Metropolitan Life Insurance Company, New York, NY  
 Small Market Administration  
 P.O. Box 14593, Lexington, KY 40512-4593  
 Fax: 1-888-505-7446

**ENROLLMENT FORM FOR GROUP INSURANCE**  
**SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)**

Name of Employee Last First Middle			Social Security No.		Date of Birth (Mo./Day/Yr.) ____/____/____		<input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Address Street City State Zip Code				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Employee's E-mail Address				Phone No. (include area code) ( )			
Name of Employer <b>Delaware Cardiovascular Associates</b>			Customer #		Department Code (for DCA use only)		
Employer's Street Address 701 Foulk Rd, Suite 2A			City Wilmington	State DE	Zip Code 19808	Employee Work Location	
Date of Hire (Mo./Day/Yr.)		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)	
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence							
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____							
Reason for Enrollment: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____ <input type="checkbox"/> Dependent Addition							
<b>COVERAGE REQUEST DATA:</b> I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below. <b>I request the following coverage:</b> <b>Employee Coverage</b> <input type="checkbox"/> Basic Life/Accidental Death & Dismemberment (AD&D) (or Core) <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Dental							
<input type="checkbox"/> <b>I wish to DECLINE any coverage not checked above for which I may be eligible.</b> For Life, LTD and/or STD coverage, I understand that I will be required to submit evidence of my and/or my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired. For Dental and/or Dependent Dental coverage, a waiting period may be required before I can enroll. If I request Voluntary Short Term Disability after my initial enrollment period, I understand that I can become covered for no more than \$100 of Weekly Benefit by enrolling during the next enrollment period. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____							
<b>applying for Dependent coverage (Spouse and Child), complete section below:</b> Number of dependents (including spouse) Name (Last, First, MI) Date of Birth Sex (M/F) Spouse: _____ Child(ren): _____					If dependent children are full-time students in college, vocational or trade school, please complete the following: Name of School _____ _____		

Signature of Employee or Enrollee

Date

Group Authorization Signature