MetLife

Metropolitan Life Insurance Company, New York, NY

How You Can Continue Your Group Term Life Insurance – (Portability)

What is Portability?

Portability or porting is an optional feature chosen by your former employer. It allows employees and dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate group policy. The attached medical questions (Statement of Health Form) do not need to be answered to enroll, however you or your Spouse/Domestic Partner must complete them in order to apply for Preferred Life Rates (lower). If approved by MetLife, you will be billed using the Preferred Life Rates (lower).

- If you do not complete the medical questions or do not satisfy MetLife's underwriting requirements, portable coverage will still be issued based on the Non-Preferred Rates (higher).

Once enrolled MetLife will mail you a portable certificate and your initial bill including instructions on how to set up the monthly Electronic Funds Transfer (EFT). The instructions to set up EFT can be found on the back of your bill.

- Your first bill will also include any retroactive premium due from the effective date of your portable coverage and an administrative fee. The current administrative fee is $1.00 per statement if your total portable life insurance coverage is $20,000 or more and $3.00 per statement if your total portable life insurance coverage is less than $20,000. If you only port dependent term life or AD&D, regardless of the amount of coverage, your administrative fee will be $3.00 per statement. If you enroll for EFT the monthly administrative fee is no longer charged

Why is Portable Coverage Important?

Portable coverage provides security and helps eliminate gaps in coverage that you may experience during a time of transition, even if your employment ends.

How Much Time Do I Have To Elect Portability?

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is within 15 days after your coverage ends or is reduced, you will have 31 days after your coverage ended to enroll.

  Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 8	August 31	September 1
July 31	August 15	August 31	September 1

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is given more than 15 days after your coverage ended or is reduced, you will have 45 days from the Date of This Notice to enroll.

  Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 16	September 30	September 1
July 31	August 23	October 7	September 1

- Under **no** circumstances will the option to port be extended past 91 days after the date coverage ended under your former employer's plan.

How Do I Enroll For Portable Life And AD&D Insurance Coverage For Myself And My Dependents?

1. Complete Part B beginning on page 1 of the attached Election of Portable Coverage Form and be sure to answer all sections.

2. Complete the enclosed medical questions (Statement of Health Form) only if:
   a) You are applying for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner; or
   b) You wish to increase the amount of life insurance that you previously had under your former employer's plan, either for yourself, your Spouse/Domestic Partner, or both.

3. Complete, sign and date the Designation of Beneficiary for Your Life Benefits (Part C of the attached Election of Portable Coverage Form).

What Needs To Be Mailed To Complete My Enrollment?

You must return:

a) Your Election of Portable Coverage Form, including information for yourself and if applicable your Spouse/Domestic Partner and Child(ren) (Part A and Part B); and
b) Designation of Beneficiary for Your Life Benefits (Part C)

If you are also **applying** for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner or wish to **increase** your or your Spouse/Domestic Partner's amount of life insurance you must also return the medical questions (Statement of Health) for each person.

- This mailing only contains one set of medical questions (Statement of Health Form). If the medical questions need to be completed for more than one individual, you may make a copy prior to completing or you may call the MetLife Customer Service Center for an additional set of medical questions.

Mail all correspondence to:

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Or Fax to: 1-866-545-7517

Please Note: Certain benefits and provisions that were available under the employer's group policy will no longer be applicable or may be different under your portable coverage.

For questions or assistance, contact the MetLife Customer Service Center toll-free at 1-888-252-3607, Monday – Friday between the hours of 8:00 a.m. and 11:00 p.m. (EST).

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ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is the party designated to maintain records of coverage in effect prior to the Employee becoming eligible to Port. The Recordkeeper may be the Employer, a Third Party Administrator (TPA) or MetLife.)

1. Immediately upon the Employee's eligibility for Portability, complete Part A below and Column 1 of the table on page 2 and then make a copy of this form.
2. If the Reason for the Portability Eligibility is Death of the Employee or Divorce, complete all of the fields in Part A below with the Spouse/Domestic Partner's information, not the Employee's information. In the column for Amount of Insurance Terminated or Reduced, leave the Employee amounts blank and enter the Dependent Spouse/Domestic Partner/Domestic Partner and Dependent Child(ren) amounts as applicable.
3. Provide the Employee (or Spouse/Domestic Partner in the event of Death of the Employee or Divorce) with the original or mail it to their last known address.
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER	**Date of This Notice (ex. MM/DD/YYYY):**
Employer's Name:	**Group Customer No.:** 215257
Employee Name: (First, Middle, Last)	**Date Coverage Ended or was Reduced:**
Employee's Mailing Address: (Street, City, State Zip)	
Has coverage been assigned? ☐ Yes ☒ No If yes, please specify coverage assigned _____ and attach a copy of assignment form. If coverage has been assigned this form must be mailed to the owner.	
Employee's Basic Annual Earnings: $	**Reason for Insured's Portability Eligibility:**
Recordkeeper's Name: City of Mesa Employee Benefits	
Print name of person at Recordkeeper completing Part A:	**Telephone Number:** 480-644-2299

Part B – TO BE COMPLETED BY THE EMPLOYEE		
Employee's Home Email Address:	Employee's Home Telephone No.:	
Social Security Number:	Date of Birth: (ex. MM/DD/YYYY)	Sex (M/F):
Note: If you answer Yes to any of the questions below medical questions (Statement of Health Form) must be completed for each person. This mailing only includes one set of medical questions. They may be copied or you may call the MetLife Customer Service Center number for an additional set of medical questions.		
Are you applying for Preferred Life Rates (lower) for yourself? ☐ Yes ☐ No Are you applying for Preferred Life Rates (lower) for your Spouse/Domestic Partner? ☐ Yes ☐ No		
Are you requesting an increase in Life Insurance coverage for yourself? ☐ Yes ☐ No Are you requesting an increase in Life Insurance coverage for your Spouse/Domestic Partner? ☐ Yes ☐ No		

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

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Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM

To be Completed by the Recordkeeper (Shaded areas to be completed by the Recordkeeper).		**To be Completed by the Employee** (For each Type of Coverage, please indicate whether you want to continue, discontinue, increase, or decrease the amount of insurance in the shaded column. Select just one option for each Type of Coverage).			
		Continue coverage	**Discontinue coverage**	**Increase coverage**	**Decrease coverage**
Type of Coverage	**Amount of Insurance Terminated or Reduced** Insert the actual $$ amount of coverage (i.e. $50,000)	**I want to <u>continue</u> the same amount of insurance in the shaded column.**	**I want to <u>discontinue</u> the insurance in the shaded column.**	**I want to <u>increase</u> my insurance in the shaded column by the following amount.** [1] (Ex. $25,000 means you want to increase your insurance amount in column 1 by $25,000).	**I want to <u>decrease</u> my insurance in the shaded column by the following amount.** (Ex. $30,000 means you want to decrease your insurance amount in column 1 by $30,000).
Employee [2,3]					
Basic Life	$_____	☐	☐	+ $_____	– $_____
Basic AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional Life	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4]	$X	☐	☐	+ $_____	– $_____
☒ Employee Only ☐ Employee + Dependents					
Dependent Spouse/Domestic Partner [2,3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$X	☐	☐	+ $_____	– $_____
Dependent Child(ren) [3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$X	☐	☐	+ $_____	– $_____

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[1] Increases in coverage are available annually and must be in $25,000 increments up to $250,000. For a life insurance increase the employee must complete the medical questions and be approved by MetLife. An increase in AD&D coverage only does not require the insured to complete medical questions.

[2] The maximum amount the employee can continue on a portable basis is $2,000,000. The maximum amount the Spouse/Domestic Partner can continue on a portable basis is $250,000.

[3] In order to port coverage for yourself or your dependents, you must have had that coverage under your former plan at the time of your coverage termination.

[4] AD&D coverage is available without Life Insurance coverage.

[5] Subject to state limits, the Dependent Spouse/Domestic Partner amount can be greater than the Employee Amount. For Employee and Spouse/Domestic Partner coverage: Spouse/Domestic Partner minimum is $2,500. For Spouse/Domestic Partner only coverage: Spouse/Domestic Partner minimum is $10,000. The Child minimum is $1,000.

[6] Use these fields only when Voluntary AD&D is being requested for the Spouse/Domestic Partner and/or Child because of the death of the Employee or divorce.

NOTE: All coverage amounts are subject to applicable state laws.

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Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM – TO BE COMPLETED BY EMPLOYEE

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attach a separate sheet of paper, sign and date)

Dependent	Name (First, Middle, Last)	SSN	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Spouse/Domestic Partner				
Child				
Child				
Child				

FRAUD WARNINGS

Before signing this Statement of Health 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.

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 ay 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.

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.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

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Part C – TO BE COMPLETED BY THE EMPLOYEE

DESIGNATION OF BENEFICIARY FOR YOUR LIFE INSURANCE (Dependent Life Insurance is payable as specified in the Certificate)
Only check one of the following boxes.

☐ I designate the following person(s) as my primary beneficiary(ies) for my portable term coverage(s). With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

☐ My designation of beneficiary is on a separate form which is signed, dated and attached.

The amount of insurance that is paid to you or your beneficiary will be decreased by any amount of contribution owed to MetLife.

☐ 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 (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
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 (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

DECLARATION AND SIGNATURE

The person signing below acknowledges that they have read and understand the statements and declarations made in this election form.

➤ _____ ➤ _____

Signature of Insured/Owner | Date Signed (MM/DD/YYYY)

Please Note: MetLife needs to receive the original. The signature and date above may not be altered.

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If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

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