



MetLife Critical Illness Enrollment / Change Form

OFFICE USE ONLY:

Approval _____

Effective Date _____

Name _____ Employee ID# _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Phone number _____

_____ Monthly _____ Biweekly _____ Retiree

1. _____ New Enrollment _____ Add/Drop Dependent (circle one) _____ Decline / Cancel Plan (circle one)
Complete Sections 2, 3, 4, 5, & 6 Complete Sections 2, 3, 4, 5, & 6 Complete Sections 2 & 7

2. **Qualifying event:** Please circle one and print date of the event.

____/____/____ New Employee ____/____/____ Birth* or Adoption* (circle one) ____/____/____ Marriage* or Divorce* (circle one)
____/____/____ Loss or gain of dental coverage* (circle one) ____/____/____ Other* _____
**Supporting Documentation will be required before processing.*

3. **Select your coverage:** _____ \$10,000 _____ \$20,000 _____ \$30,000

4. **Select your coverage level:** _____ Emp. Only _____ Emp./Child(ren) _____ Emp./Spouse _____ Emp./Family

5. **Dependent Information:** Employees are required to supply *supporting documentation* and/or *additional forms* for stepchildren and/or other dependents with different last names.

	Relationship	Dependent Name	Sex	Date of Birth	Social Security # {Required}
____ Add ____ Drop	Spouse				
____ Add ____ Drop	Child				
____ Add ____ Drop	Child				
____ Add ____ Drop	Child				

6. **Acceptance/Certification:**

I hereby request to be a participant under the NEISD **Critical Illness** Plan. I understand that no benefit will become effective until the latest of the effective date of the plan or the date on which I satisfy the minimum service requirement as stated in the plan document. I hereby authorize my employer to make necessary payroll deductions from my paycheck, if any are required. I reserve the right to revoke the payroll deduction authorization during the annual NEISD open enrollment period. All NEISD forms and supporting documentation must be received in the Employee Benefits office within 31 days from, and including, your qualifying event date.

I hereby certify that the above information is correct. I also understand that I must notify Employee Benefits within 31 calendar days if any dependent ceases to be eligible.

Employee Signature

Date

Campus/Department

7. **Declination or Cancellation of Benefit:**

After careful consideration, I have decided NOT to participate in or cancel the **Critical Illness** Plan benefit and waive my rights to such benefit.

Employee Signature

Date

Campus/Department