ENROLLMENT • CHANGE FORM

MetLife
Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer	Group Customer #	Coverage Effective Date(MM/DD/YYYY)
North Dakota Dental Association	**153530**	

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Email Address	Phone #	Select method of payment: ☐ Annually ☐ Semi-Annually	
☐ New Enrollment ☐ Change in Enrollment	Occupation	Base Annual Earnings (BAE) $ _____	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.

Disability Income Insurance

Select your monthly benefit:

☐ Enter a multiple of $100 $ _____

The maximum monthly benefit amount under age 50 is $10,000.
The maximum monthly benefit amount age 50-54 is $6,000.
The maximum monthly benefit amount age 55-59 is $3,000.

Benefit period to age 65 (SSNRA)

Indicate your waiting period:

☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Business Overhead Expense

Select your monthly benefit:

☐ Enter a multiple of $100 $ _____

The maximum monthly benefit amount under age 50 is $20,000.
The maximum monthly benefit amount age 50-59 is $10,000.

Indicate your waiting period:

☐ 15 days ☐ 30 days

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HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your name _____ Member's Social Security/Identification # _____

1. Your height ___ feet ___ inches Your weight ____ pounds

	Yes	No
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
4. Are you now, or have you in the past 5 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐	☐
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:	Yes	No
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate /type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss?	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐

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After completion, **sign and date the form on the last page where indicated**.
Make a copy for your records and return Harold Diers & Company Administrator, 11635 Arbor St., Suite 230, Omaha, NE 68144.

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	Yes	No
p. back, neck, knee, spinal, joint or other musculosketal disorder?	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
u. sleep apnea	☐	☐

For "yes" answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are answered "no," you may proceed directly to Section 3 below.

SECTION 2 – Please provide full details below for each "Yes" answer to the preceding questions 1- 11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes _____ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Personal Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____

SECTION 3

1. Personal Physician's Name: _____ Telephone: (_____) _____–_____
   Address (Street, City, State, Zip Code): _____
   Date of last visit (MM/DD/YYYY): _____ Reason for visit: _____
2. Are you currently taking any other prescribed medications? ☐ Yes ☐ No
   Medication: _____ Condition/Diagnosis: _____
   Prescribing Physician's Name: _____ Telephone: (_____) _____–_____
   Address (Street, City, State, Zip Code): _____

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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 contract under which you are applying for coverage was issued.

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.

Illinois 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.

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BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	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%

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and that I was actively at work for at least 30 hours. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

_____ _____ _____

Signature of Member Print Name Date Signed (MM/DD/YYYY)

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AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
    medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Member		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth