ACADEMY of GENERAL DENTISTRY | EXCLUSIVE BENEFITS

ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM

For The Academy of General Dentistry Members

MetLife
Metropolitan Life Insurance Company
New York, NY 10166

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder: **THE ACADEMY OF GENERAL DENTISTRY**	Group Customer: **# 204309**

MEMBER'S ENROLLMENT INFORMATION

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street)		Date of Birth (MM/DD/YYYY)
Address (City, State, Zip)	Average Monthly Earnings	AGD Membership # (optional)
Email Address	Home Phone # / Cell Phone #	Work Phone #

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you?

☐ Yes ☐ No

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.
I understand that contributions are required for the benefits I select below.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

☐ **Voluntary AD&D**

First select your option:

☐ Member Only

☐ Member + Spouse/Domestic Partner[1] + Child(ren)

Then select your level of coverage:

Enter a multiple of $25,000 up to a maximum of $250,000. $ _____

[1]Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

ADDITIONAL INSUREDS

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

☐ Check here if you need more space. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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.

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 may 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.

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 (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%

DECLARATIONS AND SIGNATURE(S)

MEMBER

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 have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

X

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

THE ACADEMY OF GENERAL DENTISTRY
LIFE EF/SOH (10/19)

GEF09-1
DEC
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*

PAYMENT INFORMATION

I am selecting the following payment option (check one of the boxes below):

Select frequency of payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (an EFT Authorization Form will be sent to you)

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

After completion, make a copy for your records and return to:
Hagan Insurance Group, P.O. Box 1889, Sioux Falls, SD 57101
Phone: 1-877-280-6487