



Vanderburgh County Plan Benefits

Explore the coverage that makes it easy to give yourself and your loved ones more security today...and in the future.

Basic Term Life and Accidental Death and Dismemberment Insurance (AD&D)

Your employer provides you with Basic Term Life and Accidental Death and Dismemberment insurance coverage in the amount of \$15,000 for those age 64 and younger and \$10,500 for those 65 and older at a cost of .01 per month.

Supplemental Term Life Insurance Coverage Options

For You	An Amount, elected by you, which is a multiple of \$10,000 to a max of \$200,000.
For Your Spouse	An Amount, elected by you, which is a multiple of \$5,000. Max amount is the lesser of 50% of your total Basic and Supplemental Life or \$50,000.
For Your Dependent Children*	Under 6 Months - \$1,000 6 Months and older – An amount, elected by you, which is a multiple of \$2,000 to a max of \$10,000.

*Child(ren)'s Eligibility: Dependent children ages from 15 days to 24 years old and is dependent upon you for 50% of their support, are eligible for coverage.

Monthly Costs for Supplemental Term Life Insurance and Accidental Death and Dismemberment Insurance

You have the option to purchase Supplemental Term Life Insurance. Listed below are your monthly rates as well as those for your spouse (based on your age and your spouse age and the amount of coverage you want). Rates to cover your child(ren) are also shown.

Age	Your Monthly Cost Per \$1,000 of Coverage	Spouse Monthly Cost Per \$1,000 of Coverage
Under 25	\$.05	\$.06
25 - 29	\$.06	\$.07
30 - 34	\$.08	\$.09
35 - 39	\$.10	\$.10
40 - 44	\$.12	\$.13
45 - 49	\$.18	\$.18
50 - 54	\$.29	\$.33
55 - 59	\$.51	\$.54
60 - 64	\$.72	\$.98
65 - 69	\$1.27	\$1.68
70 +	\$2.06	\$2.58
Cost for your Child(ren)[†]	\$.12	

[†] Covers all eligible children

Accidental Death & Dismemberment (AD&D) coverage complements your Basic and Supplemental/ Optional Life coverage insurance and helps protect you 24 hours a day, 365 days a year.

Accidental Death & Dismemberment Coverage Options

This valuable coverage is available to you even if you already have accident insurance. It provides benefits beyond your disability or life insurance for severe accidents or loss of life on or off the job — while commuting, traveling by public or private transportation and during business trips. MetLife's AD&D insurance pays you benefits if you suffer an accident that results in paralysis or the loss of a limb, speech, hearing or sight, or brain damage or coma. If you suffer a fatal accident, benefits will be paid to your beneficiary.

Supplemental AD&D Coverage Amounts for You

Your Supplemental AD&D amount is equal to your Supplemental Term Life amount.

Supplemental AD&D Coverage Amounts for Spouse and Child(ren)

You can choose to cover your dependent spouse and child(ren) with AD&D coverage. Your dependents will be eligible for coverage amounts equal to their amounts of Dependent Term Life coverage.

Monthly Cost for Accidental Death & Dismemberment (AD&D) Insurance

Supplemental Coverage	Monthly Cost Per \$1,000 of Coverage
Employee	\$.029
Dependent Spouse	\$.016
Dependent Child	\$.045

Note: Costs for any coverages you select will be automatically payroll deducted.

Covered Losses

This AD&D insurance pays benefits for covered losses that are the result of an accidental injury or loss of life. The full amount of AD&D coverage you select is called the "Full Amount" and is equal to the benefit payable for the loss of life. Benefits for other losses are payable as a predetermined percentage of the Full Amount, and will be listed in your coverage in a Table of Covered Losses. Such losses include loss of limbs, sight, speech and hearing, various forms of paralysis, brain damage and coma. The maximum amount payable for all Covered Losses sustained in any one accident is capped at 100% of the Full Amount.

Standard Additional Benefits Include

Some of the standard additional benefits included in your coverage that may increase the amounts payable to you and/or defray additional expenses that result from accidental injury or loss of life are:

- Air Bag Benefit
- Seat Belt Benefit
- Common Carrier Benefit
- Child Care Center Benefit
- Child Education Benefit
- Spouse Education Benefit
- Hospitalization Benefit

ENROLLMENT FORM FOR VANDERBURGH COUNTY
SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer Vanderburgh County		Group Customer # 118282	Report # 118282	Sub Division	Branch
Employer's Street Address		City	State	Zip Code	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) \$	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		Hours Worked Per Week		<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Salaried	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time
Reason for Enrollment:		<input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire/First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____			

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security #	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address Street City	State Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
E-mail Address	Phone No. (include area code)		

COVERAGE REQUEST DATA:

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.

I request the following coverage:

Employee Coverage

- Basic Life (Employer Paid)
- Basic Accidental Death & Dismemberment (AD&D) (Employer Paid)
- Supplemental/Optional Life

You may elect a multiple of \$10,000 up to a maximum of \$200,000.

Note: Amounts exceeding the lesser of 3x Basic Annual Earnings or \$100,000 require a Statement of Health form.

Amount Requested: \$ _____

- Supplemental/Optional AD&D

Dependent Spouse Coverage

- Dependent Spouse Life*
- You may elect a multiple of \$5,000 up to a maximum of \$50,000.

Note: Amounts exceeding \$15,000 require a Statement of Health form.

Amount Requested: \$ _____

- Dependent Spouse AD&D

Dependent Child Coverage

- Dependent Child Life*
 - \$2,000 \$4,000 \$6,000 \$8,000 \$10,000
- Dependent Child AD&D

*Amounts will be subject to state limits, if applicable.



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If applying for Dependent coverage (Spouse and Child), complete section below.

Number of dependents (including spouse) _____

Name of Spouse (Last, First, MI)

Date of Birth

Sex (M/F)

Name(s) of Child(ren) (Last, First, MI)

Date of Birth

Sex (M/F)

Is child a full-time student?

Yes

Yes

Yes

Yes

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ADM

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of Enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer 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, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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Oklahoma: 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 intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)				
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.				
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.



Employee Signature _____

Print Name _____

Date Signed (Mo./Day/Yr.) _____

Amounts over 100,000 Employee

Amounts over 15,000 Spouse

* Only complete this form if your amount of coverage is over the above.

MetLife®

Metropolitan Life Insurance Company, New York, NY



STATEMENT OF HEALTH FORM

To be Completed by the Employer

-PLEASE PRINT CLEARLY-

Employer Name: Vanderburgh County, Customer Number: 118282, Reporting Location Number: [blank], Employer's Street Address: Room 208 Civic Center 1 NW Martin Luther King Jr. Blvd., City: Evansville, State: IN, Zip Code: 47708. Insurance Requested: [X] Supplemental/Optional Life, [] Basic Life, [] Group Universal Life, [] Group Variable Universal Life, [] Dependent Life. Enrollment Year: [blank]

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete): [blank], Employee Social Security Number (Must Complete): [blank], Insurance is for: [] Employee, [] Spouse, [] Child, Proposed Insured Name: [blank], Date of Birth (Mo Day Yr): [blank], Mailing Address: [blank], City: [blank], State: [blank], Zip Code: [blank], Business Phone Number: [blank], Home Phone Number: [blank], E-mail Address: [blank], State of Birth: [blank], Country of Birth: [blank]

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Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

- 1. Height ___ feet ___ inches Weight ___ lbs
2. Are you now: a. pregnant? b. taking prescribed medications or on a prescribed diet? c. receiving or applying for any disability benefits including workers' compensation?
3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug?
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: a. chest pain or heart trouble? b. high blood pressure, stroke or circulatory disorder? c. cancer or tumors? d. anemia, leukemia or other blood disorder? e. diabetes? f. asthma, tuberculosis, pneumonia, or other lung disease? g. ulcers, stomach or liver disorder? h. colitis, Crohn's or any intestinal disorder? i. Epilepsy, paralysis or dizziness? j. mental or nervous disorder? k. Lyme disease, Epstein-Barr or chronic fatigue syndrome? l. arthritis, carpal tunnel, or any muscle weakness? m. kidney or urinary tract disorder? n. thyroid or other gland disorder? o. back, neck or spinal disorder?
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?
7. Personal Physician: [blank] Date and reason for last visit: [blank] Address: [blank] Phone Number: [blank]

Give full details for "Yes" answers on the next page.

Make A Copy For Your Records & FAX or MAIL Completed Forms to the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069 For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

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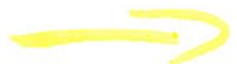
	(Employee must always sign)		Date Signed (Mo./Day/Yr.)
	Signed		
	(Proposed Insured if other than Employee and at least 18 years of age)		Date Signed (Mo./Day/Yr.)
	Signed		

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SOH/NW

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Make A Copy For Your Records & FAX or MAIL Completed Forms to the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069 For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com



Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
 - 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; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, 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.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.



Signature of Proposed Insured or
Signature & Relationship of Personal Representative*



Date Signed (Mo./Day/Yr.)

Print Name of Proposed Insured

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.