Underwritten by:
Unum Life Insurance
Company of America
2211 Congress Street,
Portland, Maine 04122

TERM LIFE INSURANCE ENROLLMENT FORM

Policy#912777

for

California Schools Benefits Trust

dba Metropolitan Employees Benefits TrustView Account Hierarchy

Applicant Name: _____ **Social Security #:** __ __ __ - __ __ - __ __ __ __

Hours Worked per Week: _____ **Date of Birth:** _____

Date of Hire: _____ **Annual Earnings: $** _____

You can purchase Life coverage for yourself and your dependents.

Employee Non-Medical Maximum	Spouse Non-Medical Maximum
• $200,000 (up to age 59) • $100,000 (age 60 up to age 69) • Employees age 70 and older, EOI required for all amounts	• $50,000 (up to age 59) • Spouse age 60 and older, EOI required for all amounts

Note: Any Life amounts over the non-medical maximum are subject to medical evidence of insurability.
The cost of your coverage may vary slightly due to rounding differences.

LIFE ELECTIONS:

Your Life Coverage: $ _____
in increments of $10,000.
Not to exceed $500,000.

Spouse Life Coverage: $ _____
in increments of $10,000.
Not to exceed $500,000.

Child(ren) Life Coverage: $ _____
in increments of $2,000.
Not to exceed $10,000.

Spouse Information *(complete only if spouse coverage is selected)*
Name: _____ Social Security #: __ __ __ - __ __ - __ __ __ __
Date of Birth: __ __ / __ __ / __ __ __ __
(Spouse primary beneficiary will automatically be Employee)

Employee Beneficiary Information:

Primary Beneficiary (ies)

Name: _____ Name: _____
Relationship: _____ Benefit %:____ Relationship: _____ Benefit %:____

Contingent Beneficiary (ies)

Name: _____ Name: _____
Relationship: _____ Benefit %:____ Relationship: _____ Benefit %:____

I understand that any coverage I am requesting is subject to all the terms of the policy including any exclusions, any provisions requiring the submission of Evidence of Insurability and approval by Unum, and any provisions specifying a Delayed Effective Date in the event that I am absent from work or an eligible dependent is totally disabled on the date coverage would otherwise begin. I also understand that if I submit Evidence of Insurability for additional coverage, the Effective Date for the additional coverage will be the first of the month coincident with or next following the date Unum approves my submission.

I certify that all statements are true to the best of my knowledge and belief and I understand a copy of this form will be made available at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective.

Employee Signature: _____ **Date:** __ __ / __ __ / __ __ __ __

PLEASE RETURN COMPLETED FORMS TO YOUR INSURANCE DEPARTMENT