aap INSURANCE PROGRAM

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Association	Group Customer #	Report #	Sub Code	Branch
American Academy of Pediatrics	156477	156477		

Date of Membership (MM/DD/YYYY)	Member ID #	Coverage Effective Date (MM/DD/YYYY)	Source Code

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)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

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.

Dental Insurance

Select your level of coverage

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

Dependent Information

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(s) of your Child(ren) (First, Middle, Last) Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female

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

[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.

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SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.**
Make a copy for your records and return the original to USI Affinity, 100 Matawan Road, Suite 200, Matawan, NJ 07747.

FRAUD WARNINGS

Before signing this enrollment 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.

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, 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 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 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.

Oregon and 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.

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.

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.

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DECLARATIONS AND SIGNATURE

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.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

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

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DEC

SUBMISSION INSTRUCTIONS

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Make a copy for your records and return the original to USI Affinity, 100 Matawan Road, Suite 200, Matawan, NJ 07747

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First Name:	MI:	Last Name:	Date:

Premium Payment Selection Form

Payment Frequency: *Please see Premium Schedule and choose one.*

☐ Monthly $_____ ☐ Quarterly $_____ ☐ Semi-Annually $_____ ☐ Annually $_____

Payment Option: *Please choose one.*

☐ **Direct Bill** – *Please enclose a check payable to **USI Affinity** for the amount selected above.*

☐ **Recurring Credit Card Payment** – *please complete this section if you would like to pay your premiums with a credit card on a recurring basis (as selected above).*

Cardholder's Name: _____

Type of Credit Card: ☐ Mastercard ☐ Visa ☐ Discover 3-digit Security Code:_____
(Located on the back of your card on the signature line)

Account #:_____ Expiration Date:_____

Cardholder's Signature:_____

☐ **Automatic Checking Account Deductions** – ***Please complete authorization below.***

Automatic Checking Account Deduction Authorization

I request and authorize the USI Insurance Services LLC (the Plan Administrator) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named below for premiums and other such payments, including future increases. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on or about the beginning of the month. I request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this Authorization shall become effective only after the initial premium(s) has been paid. I agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I understand that if premiums are not paid within the grace period allowed by the policy, as in the event any such withdrawal being dishonored, or for any other reason, then the policy shall terminate subject to any non-forfeiture provisions in the policy.

REQUIRED
Signature of Member:_____ **Date:**_____

As a convenience to me, I hereby request the Financial Institution named below to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These Authorizations shall remain in effect until revoked in writing, and mailed to the other parties at the address on record. The Company or Financial Institution shall have a reasonable time to act upon receipt of the revocation notice.

I have retained a copy of these Authorizations. ***ALL DEPOSITORS PLEASE SIGN***

REQUIRED
Name of Depositor #1:_____ **Signature:**_____ **Date:**_____

Name of Depositor #2:_____ Signature:_____ Date:_____

Financial Institution Name:_____ Account Number:_____

PLEASE ATTACH VOIDED CHECK HERE.

Automatic Saving Account Deduction is not available at this time.

If you require assistance, please call Customer Service at 800-626-0291