FedAdvantage
FILLING THE GAPS IN YOUR BENEFITS

Supplemental Disability Enrollment Form

MetLife®
Metropolitan Life Insurance Company, New York, NY

☐ New ☐ Change	Certificate #	Agent ID:	Group #:

Employer Information (Please print clearly)

Department (see reverse for codes)	Hire Date:	Position Title:

For Federal Judiciary Use Only

Circuit:	District of:	Court:	Are you a judge? ☐ Yes ☐ No

Employee Information (Please print)

Social Security Number	Name (Last, First, MI)	Mother's Maiden Name

Sex ☐ Male ☐ Female	Birth date (mm/dd/yyyy)	Email Address

Home street address	City	State	Zip code

Telephone numbers Home Work	Base annual salary Include locality, special salary rates, alternative plan, promotion pay, premium pay

Coverage Information

Please confirm your eligibility for FedAdvantage Supplemental Disability coverage:
I am an actively-at-work Employee of the United States Federal Government working at least 20 hours per week. Yes No

Are you covered under the Special Groups Retirement (Law Enforcement, Air Traffic Controller, Fire Fighter)? Yes No

I am paid on a: ☐ bi-weekly basis (26 pay periods per year) ☐ monthly basis (12 pay periods per year)	Are you a member of a Professional Association affiliated with the Federal Government? Yes No If yes, please specify:_____

Coverage election (see reverse for rates and allotment estimator)
☐ Short Term Disability only (STD)
☐ Long Term Disability only (LTD)
☐ Short Term Disability (STD) and Long Term Disability (LTD)

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in any communication materials provided me and/or the certificate issued to me. I understand that the effective date of insurance for myself is subject to my being actively at work on that date. I request arrangement for the issuance of Group Disability Coverage, underwritten by Metropolitan Life Insurance Company, for which I am or may become eligible and authorize deductions of the required contributions from my earnings. **MISREPRESENTATION**: Any person who knowingly and with intent to injure, defraud or deceive 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.

My signature below signifies my agreement with the statements and authorization above.

Employee Signature (Required)	Date

Name (Print)	

Return your completed enrollment form via fax to 888-264-6975