MetLife

Group Term Life Insurance Beneficiary Designation

- This form **MUST** be signed before you return it. See "SECTION IV – Signature" on page 3.

SECTION I - Insured Information

Customer Number KM05573437 001 POLICY Life Value $55,000

Employer Name/Group Policyholder Name Rochester Telephone Company

First Name ______ Middle Name ______ Last Name ______

Address – Street ______ City ______ State ______ ZIP Code ______

Date of Birth ______ Phone Number ______ SSN **- OR -** Employee ID Number ______

SECTION II - Plan Information

I elect that the beneficiary designation shown on this form apply only to the plans insured by MetLife that I have indicated below:

☐ All group term life coverage currently in effect **OR** ☒ Basic Life ☒ Accidental Death & Dismemberment ☐ Supplemental/Optional Life

SECTION III - Beneficiary Information

- You **MUST** designate at least one primary beneficiary. **A person may only be listed once.** Anyone listed in the primary section cannot be listed in the contingent section.
- The sum of the Primary Beneficiary percentages **MUST equal 100%.** The sum of the Contingent Beneficiary percentages **MUST equal 100%.** Dollar amounts, fractions and decimals will not be accepted.
- If you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Please complete the section that pertains to the type of beneficiary you are designating.

☐ **A. Individual Beneficiaries**

PRIMARY BENEFICIARY - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

CONTINGENT BENEFICIARY - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		Share: %
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

☐ **B. Living Trust** – ☐ Primary ☐ Contingent

If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name		Trust Date	Trustee Phone Number	Share: %
Trustee - First Name	Middle Initial	Last Name		
Trustee Address – Street	City	State	ZIP Code	

☐ **C. Testamentary Trust Created in the Insured's Will** – ☐ Primary ☐ Contingent

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

Share: %

☐ **D. Insured's Estate** – ☐ Primary ☐ Contingent

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

☐ **E. Charity/Organization** – ☐ Primary ☐ Contingent

Be sure to name the charity or organization and not the charity or organization director or an employee of that charity/organization.

Charity/Organization Name		Phone Number		Share: %
Address – Street	City	State	ZIP Code	

SECTION IV - Signature

☐ Check if you are completing and signing this form as agent for the employee under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section III as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured/Owner Name (Please Print)

_____

Insured/Owner Signature Date (must be date form was completed)

▶ _____ _____

How to Submit This Form

The employee should provide the completed form to their Employer. Retain a copy for your records.

Please note: You MUST return all pages of this form.

Enrollment Form for Group Insurance

Metropolitan Life Insurance Company
SBC Administration
P.O. Box 14593, Lexington, KY 40512-4593

MetLife®

Employee Name (Last, First, Middle)	Social Security Number	Customer Number	Division	Class

Your Home Address	City	State	ZIP	Sex (M/F)	Date of Birth	Marital Status
						☐ Single ☐ Married

Your Occupation	Employer Name	Worksite Zip Code	Hire Date	Hours Worked Per Week	Salary: $
					☐ Annual ☐ Monthly ☐ Hourly

Reason for Enrollment:

- ☑ First Time Eligible
- ☐ Change in Insurance Amount Requested
- ☐ COBRA - Original COBRA Eff. Date _____ # of Mos.
- ☐ Late Enrollee **(Statement of Health form (GEF02-1 MQ) is required)**
- ☐ Change in Enrollment Other Than Insurance Amount

Coverage Requested:

Employee Coverage

- ☑ Life/AD&D (or Core): Amount $55,000.
- ☐ Enhanced Optional Life (or Buy-Up): Amount $_____ (Not to exceed 5x Salary)
- ☐ Short Term Disability
- ☐ Voluntary Short Term Disability Amount $_____ (Sold in increments of $50)
- ☐ Long Term Disability
- ☐ Dental
- ☐ Dental Dual Option ☐ Low Plan ☐ High Plan

Spouse Coverage

- ☐ Life
- ☐ Enhanced Optional Life (or Buy-Up): Amount $ (Not to exceed 50% of Employee amount)
- ☐ Dental/Dental Dual Option

Child Coverage

- ☐ Life
- ☐ Enhanced Optional Life (or Buy-Up): Amount $
- ☐ Dental/Dental Dual Option

If applying for Dependent Coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)

Name (Last, First, MI)	Date of Birth	Sex (M/F)
Spouse		
Child(ren)		

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School	# of Hours

To decline coverage, complete this section: I understand that I have been given the opportunity to participate in the group insurance plan offered by my Employer. I am refusing the coverage(s) indicated at the right for which I am required to contribute. If I request Life and/or Disability Insurance after my initial enrollment period, I understand that I, or my dependents (for dependent life only), will be required to submit evidence of good health Satisfactory to MetLife. (Satisfactory to MetLife means MetLife has discretionary authority to determine eligibility.) For Dental Insurance, a waiting period may be required for certain services before expenses will be payable.

	Employee	Spouse	Child
Life/AD&D	☐	☐	☐
Enhanced Optional/Buy-Up Life	☐	☐	☐
Short Term Disability	☐		
Voluntary Short Term Disability	☐		
Long Term Disability	☐		
Dental/Dental Dual Option	☐	☐	☐

Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____

For employees electing Enhanced Optional (or Buy-Up) Life and Enhanced Dependent (or Buy-Up) Life Insurance, please answer the following question:

Have you or your dependent(s) (if applicable) been Hospitalized (as defined below) during the last 90 days preceding the date of this enrollment form?

Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No **Child:** ☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form (GEF02-1 MQ) is required for each person answering "Yes."

Hospitalized means admission for inpatient care in a hospital, receipt of care in a hospice facility, intermediate care facility, or long term care facility, receipt of the following treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

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. Unless designated otherwise, payments will be made in equal shares or all to the survivor. 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)
Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)

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.

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 or disability 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.

I also **understand** that if dental coverage is not elected, a waiting period for certain covered services must be satisfied before coverage for such services will take effect.

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 and Oregon: 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.

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.

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.

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.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

In any other case, read the following warning.

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 is a crime and subjects such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that he or she has read and understands the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date (Mo./Day/Yr.)

Privacy Notice To Our Customers

THIS PRIVACY NOTICE IS GIVEN TO YOU ON BEHALF OF METROPOLITAN LIFE INSURANCE COMPANY.

TO PLAN SPONSORS AND GROUP INSURANCE CERTIFICATE HOLDERS: This notice explains how we treat information we receive about anyone who applies for or obtains our products and services under employee benefit plans that we insure or group insurance contracts that we issue. Please note that we refer to these individuals in this notice by using the term "you", as if this notice were being addressed to these individuals.

Why We Need to Know About You: We need to know about you so that we can provide you with the insurance and other products and services you've asked for. We may also need information from you and others to help us verify your identity in order to prevent money laundering and terrorism.

What we need to know about you includes your address, age and other basic information. But we may have to know more about you, including your finances, employment, health, hobbies or business you conduct with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you we get mostly from you. But we may also have to find out more about you from other sources in order to make sure that what we know about you is correct and complete. Those sources may include your adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports, and they may disclose what they know about you to others.

How We Protect What We Know About You: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a MetLife product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business
- Help us comply with the law

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. By law, we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you; however, we cannot do this if the state law that applies to you does not allow it. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. Medical information will generally be disclosed through the licensed physician you choose or as otherwise required by law. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

How You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife insurance company, c/o MetLife Privacy Office, P.O. Box 2006, Aurora, Illinois 60507-2006.