NC STATE UNIVERSITY

Division of Human Resources

MetLife Group Term Life Insurance Enrollment/ Change

EMPLOYEE INFORMATION

Type of Event _____ Employee ID _____

Name (First, Middle, Last) _____ Hire Date _____

Address(Street, City, State, Zip Code) _____ Date of Birth _____

E-mail _____ ☐ Male ☐ Female Phone Number _____

TYPE OF ENROLLMENT

(Employee must be covered for dependents to apply)

Employee/Dependent Coverage _____ _____

Desired Level of Coverage: $ _____
(must be in $10,000 increments*)

*Newly hired or newly eligible employees may elect up to three times their annual base salary in $10,000 increments (up to $500,000). Amounts above three times annual base salary or greater than $500,000 require that a Statement of Health (SOH) be completed for the desired level of coverage (up to a maximum of seven times annual base salary or $1,000,000 - whichever is less).

SPOUSE/DOMESTIC PARTNER

Coverage Level _____

Name (First, Middle, Last) _____ Date of Birth _____ ☐ Male ☐ Female

*Domestic Partner Declaration Required **SOH Required (If additional dependents please attach a separate sheet)

CHILDREN COVERAGE

_____

Name of Child 1 _____ Date of Birth _____ ☐ Male ☐ Female

If your child is age 19 to 25 is he/she a full-time student? ☐ Yes ☐ No

Name of Child 2 _____ Date of Birth _____ ☐ Male ☐ Female

If your child is age 19 to 25 is he/she a full-time student? ☐ Yes ☐ No

Name of Child 3 _____ Date of Birth _____ ☐ Male ☐ Female

If your child is age 19 to 25 is he/she a full-time student? ☐ Yes ☐ No

BENEFICIARY DESIGNATION INFORMATION

(If additional beneficiaries please attach a separate sheet)
The % indicates what percent of your benefit goes to each beneficiary.

Name (First,M.I., Last) _____ Date of Birth _____ Percentage (%) _____

Address _____ Relationship _____ Type _____

Name (First, M.I., Last) _____ Date of Birth _____ Percentage (%) _____

Address _____ Relationship _____ Type _____

Name (First, M.I., Last) _____ Date of Birth _____ Percentage (%) _____

Address _____ Relationship _____ Type _____

Name (First,M.I., Last) _____ Date of Birth _____ Percentage (%) _____

Address _____ Relationship _____ Type _____

EMPLOYEE ELIGIBILITY ACKNOWLEDGEMENT

I understand if I and/or my dependent(s) do not satisfy the eligibility requirements for coverage, that person (s) will not become insured for optional life insurance until such person has furnished medical evidence of insurability satisfactory to MetLife. I understand that beneficiaries listed on this form supersede all other beneficiary choices I have made for this coverage.

Employee Signature _____ Date _____

Mailing Address:
Campus Box 7215
Raleigh, NC 27695

Submit completed form to HR Benefits:

Fax Number: (919) 513-2528

E-mail : hrsbenefits@ncsu.edu

Physical Address:
Administrative Services -Bldg II
2711 Sullivan Drive, Suite 200

Print Form

Questions about this form? Contact Benefits at (919) 515-2151