



MetLife Vision & Legal Enrollment From: Effective Date (60 days after Date of Hire) _____

Employee Information (Complete for all Employees):		
Employer Name/ Company Name Kean University	Group 5397321	Division _____ Class _____ 0001 12 Month/0002 10 Month
Employee First Name/Last Name	Social Security Number	Date of birth
Street Address/ City/ State/ Zip		
Gender	Hire Date	Email

Voluntary Coverage NOTE: Please mark the boxes for each coverage and tier you are applying.

Type of Coverage	Yes, authorizes my employer to payroll deduct premiums(s):	Monthly Deduction
MetLife Vision (5397321)	<input type="checkbox"/> Yes <input type="checkbox"/> No – Please check tier below	
- Employ Only		<input type="checkbox"/> \$8.48
- Employee + Spouse		<input type="checkbox"/> \$16.96
- Employee + Child(ren)		<input type="checkbox"/> \$19.69
- Family		<input type="checkbox"/> \$30.26
Type of Coverage	Selecting yes authorizes my employer to payroll deduct premiums(s):	Monthly Deduction
MetLife Legal (9245797)	<input type="checkbox"/> Yes <input type="checkbox"/> No – Please check tier below – \$21.25	

Dependent and other insurance information (complete for all dependents)				
	Last Name:	First Name:	Gender	Date of Birth
Spouse:				
Child:				
Child:				
Child:				

Signature Section:

My signature below indicates that I have read the descriptive material provided and understand the options available to me. I have indicated my elections above and authorize my Employer to reduce my paycheck in an amount equivalent to the required contribution for the benefits I have elected. I understand that my payroll deduction amount will change if my coverage or costs change.

On behalf of myself and as agent of my spouse and all my named dependents, if any, I hereby authorize the release of any and all medical information and/or records in the possession of any health care provider, insurance company, or other person and/or company or its agents. The release shall continue to be in effect for the duration of my coverage and so long as necessary to determine benefits provided by the program. I represent that the information provided on this form is correct and complete to the best of my knowledge and that I have read and do hereby agree to the conditions of enrollment set forth above

Employee Signature: _____ Date: _____