

ENROLLMENT • CHANGE FORM ENROLLMENT PERIOD FROM OCTOBER 20, 2025 – NOVEMBER 3, 2025

| GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper) | | | | |
|--|--------------------------------------|---------------------------|----------|--------|
| Name of Group Customer/Employer Miami-Dade County | Group Customer # 25800 | Report # 121642 | Sub Code | Branch |
| Date of Hire (MM/DD/YYYY) | Coverage Effective Date (MM/DD/YYYY) | | | |

| YOUR ENROLLMENT INFORMATION (To be Completed by the Employee) | | | | |
|--|---------------|--|--|--|
| Name (First, Middle, Last) | | Social Security # - - | <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Address (Street, City, State, Zip Code) | | Date of Birth (MM/DD/YYYY) | | |
| Phone # | Email Address | <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY) | | |
| Are you currently enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No When you select an amount below, indicate the total amount you wish to be insured for. If you are currently enrolled, that would include your current amount of insurance plus the amount you are requesting. | | | | |
| 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. ► You must complete the Health Information section of this form and the enclosed Authorization form if: <ul style="list-style-type: none"> You are enrolling for the Short Term Benefits High Plan. You are enrolling for the Long Term Benefits High Plan or Premier Plan. | | | | |
| Disability Income Insurance | | | | |
| <input type="checkbox"/> Short Term Benefits <input type="checkbox"/> Long Term Benefits <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan <input type="checkbox"/> Premier Plan | | | | |

GEF02-1
ADM
*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; **GEF02-1** applies to residents of North Dakota and Utah)*

| HEALTH INFORMATION (To be Completed by the Proposed Insured) | | |
|--|------------------------------|-----------------------------|
| Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. | | |
| Your height ____ feet ____ inches | Your weight ____ pounds | |
| 1. Are you now pregnant? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now receiving or applying for any disability benefits, including workers' compensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you tested positive for exposure to the Human Immune Deficiency Virus (HIV) infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection? | <input type="checkbox"/> | <input type="checkbox"/> |

GEF09-1
HEA
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Please retain a copy of your completed form for your records.



Yes No

5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

- a. cardiac or cardiovascular disorder?
- b. cancer, Hodgkin's disease, lymphoma or tumors?
- c. diabetes?
- d. asthma, COPD, emphysema or other lung disease?
- e. ulcers, stomach, hepatitis or other liver disorder?
- f. colitis, Crohn's, diverticulitis or other intestinal disorder?
- g. epilepsy, paralysis, seizures, dizziness or other neurological disorder?
- h. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?
- i. multiple sclerosis, ALS or muscular dystrophy?
- j. back, neck, knee, spinal, joint or other musculoskeletal disorder?
- k. mental, anxiety, depression, attempted suicide or nervous disorder?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> |

6. Are you currently taking any other prescribed medications?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

GEF09-1

HEA

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GEF09-1

HEA applies to residents of North Dakota and Utah)

7. In the past 3 years, have you been **Hospitalized** as defined below (not including well-baby delivery)?

| | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
|--------------------------|--------------------------|

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

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

GEF09-1

HEA-SUPP

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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. **California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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. **Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. **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 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.

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FW

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MetLife

Metropolitan Life Insurance Company, New York, NY 10166

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

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
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 disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for 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.
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 Employee

Print Name

Date Signed (MM/DD/YYYY)

GEF09-1

DEC

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Some services in connection with your coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and/or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and/or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, LLC ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured, including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.


Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at [P.O. Box 14069, Lexington, KY 40512-4069,] and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges receipt of MetLife's Privacy Notice and his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, your employer for a plan administration purpose or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.

I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

| | | | |
|--|--------------------------------|-------------------------|------------------------------------|
|  | _____ Signature of Employee | | _____ Date Signed (Mo./Day/Yr.) |
| | _____ Print Name | _____ State of Birth | _____ Country of Birth |