COASTAL TRANSPORT CO., INC.

1603 Ackerman Road · San Antonio, TX 78219
(210) 661-4287 · (800) 523-8612

☐ New Enrollment
☐ Co Paid ☐ Voluntary
☐ Change ☐ Cancel
Effective Date of Enrollment/Change: _____

METLIFE VOLUNTARY LIFE ENROLLMENT FORM

EMPLOYEE INFORMATION

EMPLOYEE NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)	EARNINGS	JOB TITLE
	UPON REQUEST	

EMPLOYER	GROUP NO. /ACCOUNT NO.	LOCATION
COASTAL TRANSPORT CO., INC.	**142791**	

Voluntary Life Benefits: Guarantee Issue amount for voluntary life during the initial eligibility period for Employee's is $200,000 and Spouses are $50,000. If your spouse elects more than $50,000 of coverage, they are subject to Medical Evidence of Insurability. The Spouses benefit amount may not exceed the Employee Benefit amount selected. Premium is based on individual's age and tobacco use.

Note: You must be enrolled to cover your dependents. For voluntary coverage(s) you may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period and subject to Medical Evidence of Insurability. There are no age reductions and policies are portable.

VOLUNTARY TERM LIFE COVERAGE

EMPLOYEE VOLUNTARY TERM LIFE

Select Policy Amount: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ **$200,000**
I waive this coverage: ☐ DECLINE

Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? ☐ YES ☐ NO	Has Spouse (if applicant) used cigarettes or other tobacco products in the last 2 years? ☐ YES ☐ NO

SPOUSE VOLUNTARY TERM LIFE

Select Policy Amount: ☐ $25,000 ☐ **$50,000** ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ $200,000
I waive this coverage: ☐ DECLINE

SPOUSE NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

CHILD(REN) VOLUNTARY TERM LIFE

Select Policy Amount: ☐ $5,000 ☐ $10,000
I waive this coverage: ☐ DECLINE

CHILD 1 NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	CHILD 1 DATE OF BIRTH
CHILD 2 NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	CHILD 2 DATE OF BIRTH
CHILD 3 NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	CHILD 3 DATE OF BIRTH
CHILD 4 NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	CHILD 4 DATE OF BIRTH
CHILD 5 NAME – LAST	FIRST	MIDDLE INITIAL	SEX M ☐ F ☐	CHILD 5 DATE OF BIRTH

Voluntary AD&D Benefits: Any full-time, active employee may select any amount of coverage from $50,000 to $500,000 in increments of $50,000 and you may also choose between Employee only or Family (includes Employee, Spouse, and/or Children).

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

EMPLOYEE VOLUNTARY AD&D

Select Policy Amount: ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000
☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

I waive this coverage: ☐ DECLINE

FAMILY VOLUNTARY AD&D (includes Employee, Spouse, and/or Child(ren)

Select Policy Amount: ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000
☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

I waive this coverage: ☐ DECLINE

BENEFICIARY DESIGNATION

(Employee: Must Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100% (Employee is the beneficiary of proceeds from spouse or child coverage.)

BENEFICIARY - FIRST, MIDDLE INITIAL, LAST NAME	RELATIONSHIP TO EMPLOYEE	BENEFICIARY PHONE NUMBER	BENEFIT %
Primary 1			
Primary 2			
Contingent 1			
Contingent 2			

SIGNATURE

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY(IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A MEDICAL EVIDENCE OF INSURABILITY MAY BE REQUIRED.

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. (not enforceable in OR or VA)

EMPLOYEE SIGNATURE _____ DATE ____/ /____

OFFICE USE ONLY

COMPANY PAID BASIC LIFE COVERAGE

COMPANY PAID BASIC LIFE COVERAGE FOR EMPLOYEE

☐ Class 1: Officers ☐Class 2: Supervisors & Managers ☐ Class 3: Drivers & Other Full-time Employees