MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR AMERICAN AIRLINES

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer American Airlines			STD Group Report No. 29920-G		LTD Group Report No. 38911
Employer's Street Address	City		State	Zip Code	Employee's Work Location
Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) $	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)	
Work Status: ☐ New Hire ☐ Active ☐ Rehire	Hours Worked Per Week		☐ Hourly Paid ☐ Salaried		☐ Full-Time ☐ Part-Time
Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Late Enrollee					

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Employee ID #	SSN#	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City State Zip Code				
E-mail Address	Phone No. (include area code)			

COVERAGE REQUEST DATA:
I have received and read a copy of my employer's current announcement of the group plan. I want to be covered for the benefits for which I am or may become eligible, requested below.

I request the following Employee coverage:

☐ Optional Short Term Disability (OSTD)	☐ Long Term Disability (LTD)
This coverage is provided under a policy of group insurance issued by MetLife.	Important Notes: This coverage is provided on a non-insured basis by American Airlines and is not available to employees of the Transport Workers Union.

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Medical Information

Please complete all questions below. Omitted information will cause delays. In the Medical Information section, "you" and "your" refers to the person for whom coverage is requested.

	Employee
1. Are you now pregnant?	☐Yes ☐No
2. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:	
a. chest pain or heart trouble?	☐Yes ☐No
b. high blood pressure, stroke or circulatory disorder?	☐Yes ☐No
c. diabetes?	☐Yes ☐No
d. mental or nervous disorder?	☐Yes ☐No
e. arthritis, carpal tunnel, or any muscle weakness?	☐Yes ☐No
f. back, neck or spinal disorder?	☐Yes ☐No
3. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐Yes ☐No
4. Are you now receiving or applying for any disability benefits including workers' compensation?	☐Yes ☐No
5. Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?	☐Yes ☐No

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, you must also complete a Statement of Health form, which will be sent to you by MetLife.

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Make A Copy For Your Records & FAX or MAIL Completed Form to the
SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, 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.

The employee **declares** that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability 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.

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.

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.

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.

Kansas, Oregon, and Vermont: 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.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

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