

STATE OF FLORIDA

METLIFE LEGAL PLANS ENROLLMENT FORM

Please complete and return this form to your Personnel Office

Name (please print: _____
Last First M.I

Home Address: _____
(please list the address that you would like to receive your MetLife Legal Plans information)

City: _____ State: _____

Social Security Number: _____ Home Zip Code: _____

State Agency: _____ People First ID#: _____

Date of Hire: _____

Authorization

I wish to ACCEPT enrollment in the MetLife Legal Plan and authorize, now or hereafter, the appropriate deductions to be taken from my wages for this plan. I understand my enrollment is effective for one full year, and cannot be cancelled until the next open enrollment period.

Employee's Signature: _____ Date: _____
Required for processing

For Personnel Use Only

Miscellaneous Deduction Code #257 Premium: \$17.25 Monthly \$7.96 Bi-Weekly

Date Processed: _____ Processed By: _____

Effective Date of Coverage: 7/1/2020

