SAGINAW PLUMBERS & PIPEFITTERS U.A. LOCAL NO. 85
FRINGE BENEFIT FUNDS
P.O. Box 1350 ● Troy, MI. 48099-1350
(248) 641-4985 (800) 582-6181

«FIRST_NAME» «MI» «LAST_NAME»
«ADDRESS_1»
«ADDRESS_2»
«CITY», «STATE» «ZIP»

OPEN ENROLLMENT 2026

Dear Participant,

Open Enrollment has begun for the 2026 benefit period. In 2026, you have the choice of the Blue Cross PPO Plan or the Core Plan. The Core plan is available to those participants that are eligible for benefits through a spouse; therefore, you must provide proof of other coverage to enroll in this option. We understand how busy your schedule is and we don't need to burden you with unnecessary paperwork. **If you are happy with your election choice that is currently in place, you do not need to do anything further. You and your eligible dependents will continue to have the same coverage in 2026 that is in effect today**.

You are currently enrolled in:

«Description»

Please review the coverage options that are available to you and your family. If you wish to change your enrollment selection, you must notify the Benefit Office with your choice of coverage no later than **December 5, 2025**.

Our goal is to provide you with optimum member satisfaction. If you have any questions regarding your healthcare benefits, as always, feel free to contact the Benefit Office at (248) 641-4985 or toll free at (800) 582-6181.

Sincerely,

Eligibility Department
Saginaw Plumbers & Pipefitters U.A. Local No. 85 Fringe Benefit Funds

SAGINAW PLUMBERS & PIPEFITTERS
U.A. LOCAL NO. 85 FRINGE BENEFIT FUNDS
P.O. Box 1350 • Troy, MI 48099-1350
(248) 641-4985 (800) 582-6181

To: **Active Participants in the Community Blue Program, Non-Medicare Early Retirees, and their Spouses and Dependents in the Saginaw Plumbers & Pipefitters Local 85 Health and Welfare Fund (the "Plan")**

Re: **Open Enrollment, Annual Notices, and Upcoming Benefit Changes**

Date: **November 2025**

WHAT IS THIS NOTICE ABOUT?

The Board of Trustees is pleased to provide you with the enclosed materials:

→ **Summary of Benefits and Coverage (SBC):** Enclosed is the 2026 Summary of Benefits and Coverage (SBC), which outlines several benefits available to you under the Plan. Please share the SBC with your family members who are eligible for coverage under the Plan. The Patient Protection and Affordable Care Act (PPACA) requires that all group health plans provide participants and beneficiaries with the SBC annually. The SBC provides a general description of some of the Plan's benefits and costs. The PPACA requires use of a form template and has strict rules on the format and content of the SBC. For this reason, the SBC does not cover all of the benefits provided by the Plan. We recommend you refer to the Plan's Summary Plan Description (SPD) for a more complete description of the benefits provided by the Plan, as well as the eligibility rules.

→ **Annual Open Enrollment:** Enclosed is the annual Open Enrollment Form. If your spouse or dependent child (under age 26) are not currently receiving health coverage under the Plan, you may enroll them during the month of November. If you wish to change your coverage to the prescription drug-only plan, you may also do so this November. To enroll your spouse and/or child for coverage beginning in January 2026 or if you wish to switch to the prescription drug-only plan in January 2026, please complete the enclosed form and return it to the Plan Office no later than November 30, 2025. If the Plan Office does not receive the form by November 30, 2025, your spouse and/or child will not be covered, and you will not be able to change your coverage for 2026. You must then wait until the next open enrollment period in November 2025 to enroll your spouse and/or child or change your coverage in 2026.

→ **Protections against Surprise Billing:** As a result of the No Surprises Act (the NSA), you now have protections against "surprise billing" from out-of-network providers in certain circumstances. The intent of the NSA is to provide greater transparency for health plan participants to better understand billing practices and prevent surprise billing (or balance billing) in certain situations. Specifically, the NSA provides that: 1) your cost sharing for out-of-network emergency facilities is to be the same cost-sharing as in-network emergency facilities; 2) if you go to an in-network facility (for either emergency or non-emergency service), your cost-sharing for out-of-network providers within that facility will be no more than your in-network cost sharing amount; and 3) cost-sharing for out-of-network air ambulance services will also be limited to cost-sharing for in-network air ambulance services. The Plan has been updated to reflect these changes. Hospitals and doctors are also required to provide you with notice of your rights and protections under the NSA. If you receive a balance bill after receiving these services covered by the NSA (for example, you are charged the out-of-network cost-sharing for an emergency air ambulance), you may be able to appeal this charge under the Plan's claims and appeals procedures, which are outlined in the Summary Plan Description.

→ **Auto & Motorcycle Accidents**: Michigan changed its no-fault auto insurance laws on July 1, 2020, to allow you to

opt-out or buy reduced medical coverage on your auto policy. To opt-out or buy reduced medical coverage on your auto policy, the new law requires you to have medical coverage elsewhere for injuries related to auto accidents. THIS PLAN DOES NOT COVER CLAIMS FOR ANY INJURIES RELATED TO AUTO ACCIDENTS; THEREFORE, YOU ARE NOT ELIGIBLE TO OPT-OUT OR BUY REDUCED MEDICAL COVERAGE ON YOUR AUTO INSURANCE POLICY. For injuries incurred because of a motorcycle accident, this Plan provides coverage only after all other sources of insurance that provide coverage have been fully exhausted, and only for those amounts which were not paid by these other sources of insurance to the extent the claims are otherwise covered by this Plan.

- Injuries related to recreational vehicle accidents (such as quad sports and snowmobiles that are NOT licensed for road use) ARE covered by the Plan. Again, if you incur medical claims because of an accident involving any type of vehicle that CAN be licensed for road use in Michigan (has a license plate or equivalent road use permit), this Plan will NOT cover those medical claims.

- Be sure that you inform your insurance agent about these coverage exclusions and limitations in your Plan! When you are purchasing no-fault automobile or motorcycle insurance, BE SURE TO INCLUDE MEDICAL COVERAGE IN YOUR AUTOMOBILE AND MOTORCYCLE POLICIES, SO THAT YOU DO NOT RUN THE RISK OF HAVING NO COVERAGE FOR MEDICAL CLAIMS RESULTING FROM AN AUTOMOBILE AND LIMITED COVERAGE FOR MOTORCYCLE ACCIDENT. You may want to take this notice to your insurance agent, when purchasing that coverage, to better explain your current medical coverage to your insurance agent.

→ **Women's Health and Cancer Rights Act Annual Notice.** As required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), the Plan provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Call the Benefits Office at 248) 641-4985 or toll free at (800) 582-6181 for more information.

→ **Newborns' and Mothers' Health Protection Act** The Newborn's and Mothers' Health Protection Act of 1996 ("Newborn's Act") is a Federal Law that contains important protections for mothers and their newborn children concerning the length of the hospital stay following childbirth. The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

→ **Optional Life Insurance Enrollment**: The Plan offers optional life insurance through MetLife. If you wish to purchase additional life insurance, you will have to complete the enclosed enrollment form and complete the medical questionnaire, as well as return the enclosed payroll deduction form to the Benefit Office.

Receipt of these documents does not constitute a determination of your eligibility, nor is it a contract. Additional limitations and exclusions may apply. If you have any additional questions about your benefits, please call the Benefit Office at (248) 641-4985 or toll free at (800) 582-6181.

Sincerely Yours,

Board of Trustees
Saginaw Plumbers & Pipefitters Local 85 Health and Welfare Fund

Enclosures:
-2026 Summary of Benefits and Coverage for Actives and Early Retirees (SBC)
-Open Enrollment Form

Coverage for: Participant, Spouse, Family | **Plan Type:** PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call (248) 641-4985 or (800) 582-6181. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can call (248) 641-4985 or (800) 582-6181 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person / **$1,000** family (in-network) **$1,000** person / **$2,000** family (out-of-network) Does not apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. In-network **preventive care**, office visits and prescription drugs are covered before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other deductibles for specific services?	There are no other specific **deductibles**.	You don't have to meet specific **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For in-network providers **$4,000** person / **$8,000** family; for out-of-network providers **$8,000** person / **$16,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. There is a separate **coinsurance limit** of **$2,000**/person and **$4,000**/family (in-network) and **$4,000**/person and **$8,000**/family (out-of-network). that accumulates toward the **out-of-pocket limit**.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, dental, vision and health care this plan does not cover.	Even though you may be required to pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See **www.bcbsm.com** or call the number on the back of your BCBSM ID card for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance after deductible	Online visits with your medical provider will be billed at the $20 copay rate.
	Specialist visit	$20 copay/visit	40% coinsurance after deductible	Online visits with your medical provider will be billed at the $20 copay rate. Chiropractic visits limited to 24 visits per year.
	Preventive care/screening/ immunization	No charge	Not Covered	Benefits covered at 100% in-network. Limitations may apply on number of visits.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	40% coinsurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbsm.com	Generic drugs	$10 co-pay for retail 30-day supply; $20 co-pay for mail order 90-day supply.	$10 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs are subject to pre-authorization and are limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
	Preferred brand drugs	$40 co-pay for retail 30-day supply; $80 co-pay for mail order 90-day supply.	$40 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs are subject to pre-authorization and are limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
	Non-preferred brand drugs	$70 co-pay for retail 30-day supply; $140 co-pay for mail order 90-day supply.	$70 co-pay plus an additional 25% of BCBSM approved amount for the drug.	Mail order drugs not covered out-of-network. Specialty drugs are subject to pre-authorization and are limited to a 30-day supply. Some drugs may be subject to pre-authorization and utilization review. Please call the number on the back of your BCBSM ID card for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	---none---
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need immediate medical attention	Emergency room care	$50 co-pay	$50 co-pay	Copay is waived for in-patient admissions or accidents
	Emergency medical transportation	20% co-insurance after deductible	30% co-insurance after deductible	---none---
	Urgent care	$20 co-pay	40% co-insurance after deductible	---none---
	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	---none---

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Your cost-share may be different for services performed in an office setting.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you are pregnant	Office visits	20% coinsurance after deductible (No charge for prenatal and postnatal preventive services required by federal law)	40% coinsurance after deductible	In-network prenatal and postnatal care are provided at no charge as required by federal law. Limitations on number of visits may apply.
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	---none---
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	---none---
	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Physical, Occupational, Speech therapy is no longer limited to a maximum of visits per member, per calendar year.
	Habilitation services	Not Covered	Not Covered	---none---
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	---none---
	Durable medical equipment	20% coinsurance after deductible	30% coinsurance after deductible	---none---
	Hospice services	No Charge	No Charge	Up to 28 pre-hospice counseling visits before electing hospice; four 90-day periods; only provided only by participating hospice programs.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Discounted vision services available through the Fund Office. Please call (248) 641-4985 or (800) 582-6181 for more information.
	Children's glasses	Not Covered	Not Covered	Discounted vision services available through the Fund Office. Please call (248) 641-4985 or (800) 582-6181 for more information.
	Children's dental check-up	Not Covered – coverage available under a separate plan.	Not Covered – coverage available under a separate plan.	Dental benefits are provided through Delta Dental. Please call (248) 641-4985 or (800) 582-6181 for more information.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Infertility treatment • Routine foot care	• Cosmetic surgery • Long-term care • Weight loss programs	• Routine eye care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care • Coverage provided outside the United States. See http://provider.bcbs.com	• If you also have a balance in your Individual Account Plan (IAP), then you may have access to additional funds to help cover certain out-of-pocket expenses – like the deductible, co-payments, or co-insurance, or benefits not otherwise covered.	• Hearing aids • Private-duty nursing • Dental Care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the Fund Office at (248) 641-4985 or (800) 582-6181.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (248) 641-4985.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (248) 641-4985.]
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (248) 641-4985.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (248) 641-4985.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *[cost sharing]*	$20
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

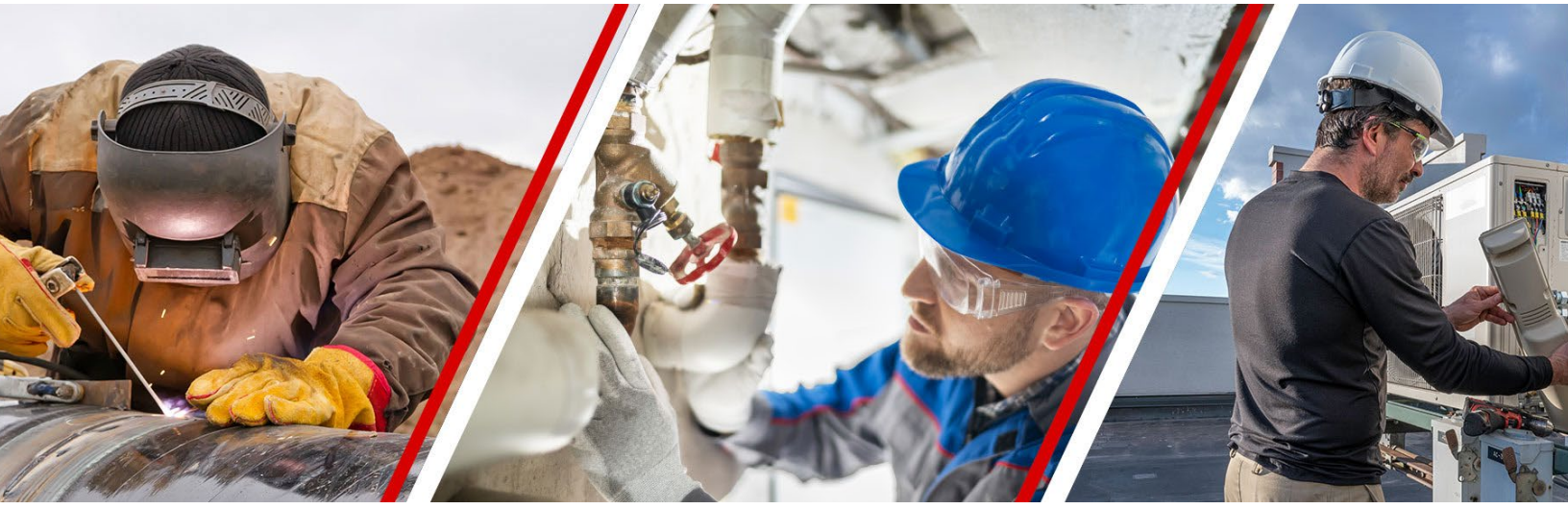
Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$1,300**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Enrollment Reminder



Enrollment Reminder

Open Enrollment is Here!

2026 Annual Benefits Enrollment

Scan the QR Code Below to Review your Benefit Guide: Or you can enter this link into your web browser:
Saginaw Plumbers & 85 Benefit Guide - Active CORE- Flipsnack

Scan the QR Code Below to Review your Benefit Presentation: Or you can enter this link into your web browser:
https://www.brainshark.com/usi/vu?pi=zJOzxOrwSzohk6z0

Saginaw Plumbers & Pipefitters-Local 85
P.O. Box 1350

Troy, MI 48099-1350

Recipient Name
Recipient Address

Open Enrollment is Here!

2026 Annual Benefits Enrollment

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Saginaw Plumbers & Pipefitters-Local 85
P.O. Box 1350

Troy, MI 48099-1350

Recipient Name
Recipient Address

OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Trustees of the Plumbers & Pipefitters Local 85 Insurance Fund offer to all eligible, active participants, the option to purchase Optional Life and Accidental Death and Dismemberment (AD&D) Insurance coverage through MetLife. You can enroll yourself and your family in these plans, at affordable group rates, during open enrollment. You can choose Optional Life, AD&D, or both.

To select the coverage amount that is right for you and your dependents, please read this entire notice and carefully review the following enclosed documents:

- Group Enrollment Form (to be completed and returned if you elect either Optional Life or AD&D)
- Rate Chart
- Application and Authorization Agreement for Direct Payments (to be completed and returned if you elect either Optional Life or AD&D)
- Statement of Health Form

Voluntary Accidental Death & Dismemberment Coverage

Coverage up to $500,000 will be available to you and your family. This coverage can be purchased with or without the Optional Life Coverage.

TO ENROLL COMPLETE AND RETURN TO THE FUND OFFICE BY <u>December 5, 2025</u>, BOTH OF THE FOLLOWING DOCUMENTS:

- **Group Enrollment Form and Application**
- **Authorization Agreement for Direct Payments**
- **Statement of Health Form**

    - Note: The cost for the Optional Life and/or AD&D benefits must be made by a deduction from your personal checking or savings account. No direct payments are permitted. The deduction will be taken from your account on or about the 10th day of each month.

If you have any questions, please contact the Fund Administration Office at (248) 641-4985 or toll free at (888) 582-6181.

Sincerely,

BeneSys Inc., on behalf of the
PLUMBERS & PIPEFITTERS LOCAL 85 INSURANCE FUND

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Saginaw Plumbers & Pipefitters Local 85 Health & Welfare Fund				
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 # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

☐ Employee ☐ Retiree	Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must also complete a Statement of Health form:
- If you are enrolling for more than $150,000 of Supplemental/Optional Life Insurance
- If you are enrolling for more than $50,000 of Dependent Spouse Life Insurance

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance

☐ Basic Life [1] / Basic AD&D

☐ Supplemental/Optional Life [1] / Supplemental/Optional AD&D
☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ $200,000
-Select a multiple of $25,000 up to a maximum of the lesser of 5x your Basic Annual Earnings or $200,000.

☐ Dependent Spouse [2] Life [1,3] / Dependent Spouse [2] AD&D
☐ $12,500 ☐ $25,000 ☐ $37,500 ☐ $50,000 ☐ $75,000 ☐ $100,000
-Member must be enrolled. Spouse election cannot exceed 50% of member election.
-Spouse rates based on member age.

☐ Dependent Child Life [3] Dependent Child AD&D to age 26

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] For Vermont and Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

[3] Amounts will be subject to state limits, if applicable.

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

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.

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 to the extent required by applicable law.

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.

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.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%
If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **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.
4. I understand that if I do not enroll for life 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.
5. 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.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

Metropolitan Life Insurance Company

Your life insurance claim kit

On behalf of MetLife, please accept our sincere condolences during this difficult time.

We're here to help

We recognize this may be a challenging time for you. If you have questions, or need help preparing your claim, call us at **1-800-MET-6420 (1-800-638-6420)**. Our Customer Service Center is open Monday through Thursday, 8:00 a.m. to 8:00 p.m. EST, and Friday 8:00 a.m. to 5:00 p.m. EST.

Sincerely,

MetLife
U.S. Life Insurance Claims

MetLife

State Specific Fraud Warnings – Group Product Claim Forms

Fraud Warnings

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

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.

Idaho, Indiana and 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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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 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.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under 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.

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.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim 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.

MetLife

Life insurance claim form

□se t□is form to submit □our claim for a life insurance polic□ pa□ment.

Things to know before you begin

- □ □ac□ beneficiar□ submitting a claim must complete and sign a separate claim form. □o□e□er□□e onl□ need one deat□ certificate indicating t□e cause and manner of deat□.
- □ □ signature is re□uired for t□is claim to be processed.
- □ Please ans□er eac□ □uestion full□ and accuratel□. If □ou return t□is form □it□ missing or incorrect information□it □ill dela□ □our claim.
- □ □ou ma□ □a□e to send us ot□er documents □it□ t□is claim. See t□e list in *Section 5: How to submit this form.*

Please correct and initial an□ errors on t□e form.

□ signature is re□uired for t□is claim to be processed

SECTION 1: About you

Tell us in □□at capacit□ □ou□re ma□ing a claim ***(check one)***:

☐ Indi□idual beneficiar□ or ☐ Representati□e of a trust□estate or C□arit□

□our relations□ip to t□e person □□o died *(check one):*

☐ Spouse/Partner ☐ Parent ☐ C□ild

☐ Trust/□state Representati□e/C□arit□ ☐ Ot□er *(please explain)* _____

□our name *(first, middle, last) - Please print your name the way you want it to appear on your payment.*

First	Middle	Last

Maiden or ot□er names *(if applicable)*

Mailing address *(Street number and name, apartment or suite)*	P□one number

Cit□	State	□IP code

Date of birt□ *(mm/dd/yyyy)*	Sex *(M/F)*	Social Securit□ number	Countr□ of Citi□ens□ip

Please complete if ma□ing a claim on be□alf of a Trust□□state or C□arit□

□ame of Trust/□state/C□arit□	Date of Trust *(mm/dd/yyyy)*

Tax Identification □umber *(For the Trust, Estate, or other Charity)*

_____

☐ I consent to rece□e claim status e-mails and text messages as indicated belo□. Please see t□e enclosed *About Electronic Statusing* for more details.

Please tell us if □ou □ould li□e to rece□e claim statuses electronicall□

Cell p□one number	□mail address

Insured Employee/Member Information

First name	Middle name	Last name

□mplo□er name

□a□e □ou signed a document □it□ a funeral □ome t□at aut□ori□es us to ma□e a pa□ment directl□ to t□em□ T□is document is usuall□ referred to as a funeral □ome assignment.

☐ □o ☐ □es □ If □es□please send us a cop□ of t□e document □it□ t□is claim form.

SECTION 2: About the deceased

□ame *(first, middle, last)*

First	Middle	Last

Maiden or ot□er names *(if known, optional)*

Residence address *(Street number and name, apartment or suite)*

Cit□	State	□IP code

Date of birt□ *(mm/dd/yyyy)*	Date of deat□ *(mm/dd/yyyy)*

Social Securit□ number	Marital status *(check one)*
	☐ Single ☐ Married ☐ Di□orced ☐ Separated ☐ □ ido□/□ido□er

SECTION 3: Tell us how you want to receive your claim payment

□ou □ill recei□e a c□ec□ for □our pa□ment

Please remember to sign and date t□e form on t□e next page

Insured Employee/Member Information

First name	Middle name	Last name

Employer name

SECTION 4: Certification and signature

By signing this claim form, you certify that:

- All the information you have given is true and complete to the best of your knowledge.
- Any contributions owed by the insured will be deducted from the insurance proceeds paid to me.
- If we overpay you, we have the right to recover the amount we overpaid. This can happen if we find we've paid you more than you're entitled to under this life insurance claim, or if we paid you when we should have paid someone else. You agree to repay us the amount we overpaid. You also understand that if you do not repay us, we may take steps (including legal action) to recover the overpayment.
- You have read the Claim Fraud Warnings included with this form. **New York residents:** 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Under the penalties of perjury, I certify:

1. That the number shown as my Social Security Number or Tax Identification Number in "Section 1 – About You" above is my correct taxpayer identification number; and
2. That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen, resident alien, or other U.S. person*; and
4. I am not subject to FATCA reporting because I am a U.S. person, and the account is located within the United States.

(Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

**If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out items 3 and 4 above, and complete and submit form W-8BEN (individuals) or W-8BEN-E (entities).*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. You must complete this certification to avoid 24% withholding with respect to taxable amounts.

Signature of person making the claim	Date signed *(mm/dd/yyyy)*

Some services in connection with your claim may be performed by our affiliates, MetLife Global Operations Support Center Private Limited or MetLife Services and Solutions, LLC, unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your claim will be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

Insured Employee/Member Information

First name	Middle name	Last name

□mplo□er name

SECTION 5: How to submit this form

5A. Check off the additional items you’re sending with this claim form

- ☐ **A death certificate.** □ e re□uire a cop□of t□e deat□ certificate. T□e funeral director ta□ing care of t□e funeral arrangements can usuall□pro□ide a cop□of t□e deat□ certificate *(indicating the cause and manner of death)*. **We only require one death certificate** □if □ou□re a□are of anot□er claimant □□o□s sending one□ □ou don□t □a□e to send it.
- ☐ If □ou signed a document □it□a funeral □ome t□at aut□ori□es us to ma□e a pa□ment directl□to t□em□a cop□of t□at document.
- ☐ If t□e beneficiar□is t□e estate and □ou are a representati□e of an estate□a cop□of t□e appointment papers issued b□t□e courts.
- ☐ If t□e beneficiar□is a trust and □ou are a trustee□a notari□ed statement t□at t□e trust is still in effect and □ou are aut□ori□ed to act under t□e trust. If □ou are not t□e original trustee□a cop□of t□e page naming □ou as t□e successor trustee.
- ☐ If □ou are submitting t□e claim as Po□er of □ttorne□for t□e beneficiar□□a cop□of t□e PO□ papers for t□e beneficiar□must be pro□ided.

5B. Submission instructions

□nless □ou □a□e been ad□ised of different instructions b□t□e administrator/emplo□er□return t□is signed claim form and t□e documents □ou□□e c□ec□ed off abo□e in t□e en□elope included □it□t□is pac□age□or mail/fax t□em to□

Mail:

MetLife Group Life Claims
P.O. Box □100
Scranton□P□ 1□505-□100

Fax:

1-5□0-55□-□□□5

Email:

Lifeclaimsubmit□ metlife.com

Please note□Most claims are re□ie□ed □it□in fi□e □5□ business da□s.

If faxing□please remember to fax bot□ front and bac□sides of t□e signed claim form. □llo□ t□o □2□ □ours for documents to be recei□ed.

If emailing□please be ad□ised□

□ccepted document t□pes□□ ord Document□PDF and □P□G.

Maximum single attac□ment si□e□20MB

Maximum email si□e□25MB

□ncr□pted emails cannot be accepted

We're here to help

If □ou □a□e □uestions□or need □elp preparing □our claim□call us at 1-□00-M□T-□□20 □1-□00-□□□-□□20□□t□en press 2. Our Customer Ser□ice Center is open Monda□t□roug□T□ursda□□ □□00 a.m. to □□00 p.m. □ST□and Frida□ □□00 a.m. to 5□00 p.m. □ST.

About Electronic Statusing

MetLife pro□ides electronic statusing as a con□enience to □ou. Please re□ie□ t□e follo□ing terms and conditions carefull□before pro□iding □a□□our agreement to t□em□and □b□□our consent to recei□ing electronic statuses.

B□agreeing to t□e terms of t□is □greement□□ou are consenting to recei□e claims statuses in one or more of t□e follo□ing □a□s□

1. □ □en a c□ange □as been made to □our claim□□e □ill send □ou an email ad□ising □ou t□at □e □a□e made suc□a c□ange□

Suc□e-mails □ill be sent to t□e current e-mail address □e □a□e on file for □ou. In addition□□e can notif□ □ou about t□e a□ailabilit□of claim statuses b□text message □SMS - S□ort Messaging Ser□ice□ If □ou agree to recei□e notification of t□e a□ailabilit□of claim status messages b□text message□□ou ac□no□ledge and agree t□at an□c□arges associated □it□ □our receipt of t□ese messages are full□ □our obligation and are not reimbursable b□MetLife or an□of its affiliates. T□ere ma□be ot□er t□ird part□costs for Internet access fees or text message □SMS□c□arges t□at are not reimbursable b□MetLife or an□of its affiliates.

□ e □ill continue to deli□er information in □riting to □ou b□□.S. mail.

2. □ou ma□ □it□dra□ □our consent□c□ange □our deli□er□preferences□and update information □e need to contact □ou electronicall□at an□time b□repl□ing "stop" to a text message from us or b□calling our Customer Ser□ice Department.

PLUMBERS & PIPEFITTERS LOCAL 85
FRINGE BENEFIT FUNDS
P.O. BOX 1350
TROY, MICHIGAN 48099-1350
(248) 641-4985 (800) 582-6181

Authorization Agreement for Voluntary Life Insurance (ACH DEBITS)

Name of Participant: _____ Social Security: _____

Address: _____

City: _____ State: _____Zip:_____

Telephone Number: _____

BANK INFORMATION

The bank that you specify must be a member of the Automated Clearing House. Most banks are, and yours probably is, but if not, they will let you know what alternatives are available.

I request that my monthly self-payment for Metlife coverage be electronically transferred from my:

Checking Account_____ **Savings Account_____**

Please only choose one option above.
Please include a voided check or deposit ticket for a savings account.

FINANCIAL INSTITUTION INFORMATION

Bank Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Your Account Number: _____

ABA Number (Bank I.D. Number): _____

YOUR AUTHORIZATION

I hereby authorize Local 85 Insurance Fund, to initiate debit entries from my account indicated above on the 10th of every month. If an amount should be debited from my account in error or after my death, I authorize the appropriate credit adjustment to be made to my account.

Participant Signature: _____ Date: _____

Additional Signature: _____ Date: _____

(If joint account BOTH persons must sign this authorization)

Virtual Second Opinions
By Cleveland Clinic

Direct access to a Cleveland Clinic expert physician for peace of mind

72% of educational opinions uncover potential diagnosis changes or treatment plan modifications

The Clinic 2020 outcomes data, n=417

Through Saginaw Plumbers and Pipefitters Local 85 Health and Welfare Fund, you have access to The Clinic by Cleveland Clinic's Virtual Second Opinions program. The program provides you with easy, secure access to high-quality medical expertise from the comfort of home.

Through this digital health service, you can have your medical diagnosis and treatment plan reviewed by an expert physician at Cleveland Clinic and receive an educational opinion by video consultation and written report in about two weeks.

The Clinic supports you every step of the way. From collecting and reviewing medical records to identifying the best specialist for your needs, the program saves you time, trouble, and travel on your path to peace of mind — **all at no cost to you.**

What is a Virtual Second Opinion?

- A health service to have a diagnosis and treatment plan reviewed by expert physicians at the world-renowned Cleveland Clinic
- Personalized matching with one of 3,500 Cleveland Clinic expert physicians in one of over 550 advanced sub-specialties
- 100% confidential and included in your benefits package at no cost to you

We encourage you to obtain a second opinion if you are:

- Diagnosed with a serious condition
- About to make a major decision about a medical next step, such as surgery
- Considering a treatment that involves risk or has significant consequences
- Dealing with a condition or chronic illness that isn't improving or is getting worse

How it works

Live intake with nurse care manager

Records collection

Records and tests review

Expert physician matching

Expert physician review

Opinion delivered by expert physician

Get a Virtual Second Opinion from Cleveland Clinic today

Scan the QR code to the right or follow the link below to learn more, register, and download the app.
Go to: **www.clinicbyclevelandclinic.com/local-85**
Once prompted, enter the service key: **LOCAL85**

UA LOCAL 85
PLUMBERS, STEAMFITTERS & HVACR SERVICE TECHNICIANS

Cleveland Clinic is ranked one of the nation's top hospitals and No. 1 for heart care in *U.S. News & World Report*'s "2022-23 Best Hospitals" rankings.

Questions? Call us at 844-777-0788 from 8:00 a.m. to 5:00 p.m. ET Monday through Friday.

INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse/Domestic Partner or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

For **QUESTIONS**, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at LMSOH@metlifeservice.com.

Metropolitan Life Insurance Company,
Medical Underwriting
P.O. Box 14593
Lexington, KY 40512-4593
FAX: 1-888-505-7446
To submit by Email:
METLIFESOH@metlife.com

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer.

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.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association	Group Customer #	Class	Reporting Location #

Street Address	City	State	Zip Code

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year

Term Life Insurance

- ☐ Basic Life (Core): Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Life (Buy up): Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse/Domestic Partner Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Dependent Spouse/Domestic Partner Life (Buy up): Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Dependent Child Life (Buy up): Indicate amount subject to medical underwriting $_____

EMPLOYEE INFORMATION (To be Completed by the Employee)

Name of Employee (First, Middle, Last)		Social Security # of Employee
☐ Employee ☐ Retiree	Date of Hire (MM/DD/YYYY)	Employee's Basic Annual Earnings $

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee ☐ Self ☐ Spouse/Domestic Partner ☐ Child
Street Address	City	State / Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone # / Home Phone #	Email Address

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
ADM *applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

HEALTH INFORMATION

SECTION 1

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. Health Information is required for the Proposed Insured only. For questions 5 through 11p, for "yes" answers, please provide full details in Section 2.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
5. 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?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. 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? Indicate reason _____	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **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.	☐	☐
10. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? **For CT residents, please answer the following question:** To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Indicate type _____	☐	☐
b. stroke or circulatory disorder? Indicate type _____	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
i. memory loss? Indicate type _____	☐	☐
j. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
k. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
l. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
m. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
n. thyroid or other gland disorder? Indicate type _____	☐	☐
o. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
p. sleep apnea? Indicate type _____	☐	☐

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11p.

Personal Physician Information

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (___) ___–____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (___) ___–____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (___) ___–____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11p in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (___) ___-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (___) ___-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (____) ____-_____

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

FRAUD WARNINGS

Before signing this Statement of Health 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.

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 to the extent required by applicable law.

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.

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.

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

Please complete all sections of this form. Incomplete forms will be returned to you.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health 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 have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Sign Here

Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

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 Group, Inc ("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, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - 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 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, 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 protected by Federal Regulations 42 CFR part 2, 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.

Sign Here

Signature of Proposed Insured _____ Date Signed (MM/DD/YYYY) _____

Print Name _____ State of Birth _____ Country of Birth _____

If a child proposed for insurance is age 18 or over, the child must sign this Authorization form. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

Signature of Personal Representative _____ Print Name _____ Date Signed (MM/DD/YYYY) _____

Relationship of Personal Representative _____