STATE OF FLORIDA

METLIFE LEGAL PLANS ENROLLMENT FORM

Please complete and return this form to Capital Insurance Agency

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: _____ Email Address: _____

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 **Monthly Premium:** $20.75 **Biweekly Premium**: $9.58

Date Processed: _____ **Processed By:** _____

Effective Date of Coverage: _____

MetLife