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: ______________________

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: $17.25** **Biweekly Premium: $7.96**

Date Processed: ______________________ **Processed By:** ______________________

Effective Date of Coverage: ______07/01/2020______

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