Send to: CPF Insurance Trust
P.O. Box 27098
Fresno, CA 93729-7098
1-888-811-0811
Fax (888) 273-6630
Email- info@hjwii.com

MetLife Legal Plan
Enrollment Form

Local: _____

Member's Name: _____
Last First M.I.
Address :_____
Street
Date of Birth: _____ Soc. Sec. No: _____/_____/_____
mm / dd / yyyy
Home Phone: (_____) _____ Work Phone: (____)_____

E-mail Address: _____

One Monthly Premium: $16.50 per month for you, spouse & eligible dependents under 26 years old. Please list family members that you would like to have covered on the plan.

Check Choice of Plan: (Check desired coverage option)

□ Member Only □ Member + Dependent Coverage

Spouse:
Name: _____
Last First M.I.
Date of Birth: _____ Soc. Sec.# ____/___/_____

Dependents:(under 26 years old)
Name: _____
Last First M.I.
Date of Birth: _____ Soc. Sec.# ____/___/_____

Name: _____ _____
Last First M.I.
Date of Birth: _____ Soc. Sec.# ____/___/_____

Name: _____ _____
Last First M.I.
Date of Birth: _____ Soc. Sec.# ____/___/_____

I acknowledge that I have read, understand, and agree to the terms and conditions of this coverage as detailed in the handout and I authorize the premium deduction from my pay for the insurance applied for as shown above.

I have been given the opportunity for this insurance but I **do not desire to participate**.

Member's Signature: _____

Date Signed: _____

Effective Date of Coverage will be **8/1/2020**