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