



DETECTIVES' ENDOWMENT ASSOCIATION, INC.

26 Thomas Street
New York, NY 10007

**GROUP LIFE INS. ENROLLMENT CARD
METLIFE GROUP POLICY #235224**

MECHANIC & ASSOCIATES Plan Administrator (845) 624-3800	DEA Benefits Office (212) 587-9120
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MEMBER INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
SOCIAL SECURITY #: _____ DOB: _____
ADDRESS: _____ ADDRESS LINE 2: _____
CITY: _____ STATE: _____ ZIP CODE: _____
EMAIL: _____ CELL PHONE: _____ HOME PHONE: _____

PRIMARY BENEFICIARY INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____
ADDRESS: _____ ADDRESS LINE 2: _____
CITY: _____ STATE: _____ ZIP CODE: _____
CELL PHONE: _____ HOME PHONE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____
DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____
ADDRESS: _____ ADDRESS LINE 2: _____
CITY: _____ STATE: _____ ZIP CODE: _____
CELL PHONE: _____ HOME PHONE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____
DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____
ADDRESS: _____ ADDRESS LINE 2: _____
CITY: _____ STATE: _____ ZIP CODE: _____
CELL PHONE: _____ HOME PHONE: _____

Primary Beneficiary(ies) Total: _____%

If the primary beneficiary dies before me, I designate as contingent beneficiary:

CONTINGENT BENEFICIARY INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____

ADDRESS: _____ ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____

ADDRESS: _____ ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____

DOB: _____ SSN: _____ RELATIONSHIP: _____ % TO SHARE: _____

ADDRESS: _____ ADDRESS LINE 2: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL PHONE: _____ HOME PHONE: _____

Contingent Beneficiary(ies) Total: _____%

I designate the people shown above as my beneficiary(ies) and contingent beneficiary(ies). If there is more than one surviving primary beneficiary or contingent beneficiary, they will share the death benefits according to the percentages identified within this form or all will be paid to the survivor(s). I reserve the right to change this designation at any time.

SIGNATURE: _____ DATE: _____