

You know that life insurance is a **critical part of your overall benefits plan** — that's why you chose to enroll in the Group Life insurance program offered by your employer. As you leave your employment, you have **options** to continue your current Group Life coverage and **maintain this important protection** for you and your family.

Now you have **important decisions to make** about continuing your Group Life insurance benefits. There are **two options** under which you can continue your coverage — **Portability** and **Conversion**. This brochure is designed to answer the most common questions about each option and give you a side-by-side comparison, so you can choose the option that best meets your needs.

IS THERE ANYTHING ELSE I NEED TO KNOW?

To continue your life coverage benefits, you will receive a notice after your group life benefits end which includes coverage amounts and eligibility dates.

If you wish to increase your coverage amount or add spouse or child coverage, the non-underwritten policy available through the Conversion process may not meet your needs. An individually underwritten policy may be more cost-effective and provide additional benefits, such as the ability to elect waiver of premium, accidental death benefit and/or a children's term rider, that are not available with a Conversion policy. You may apply for a medically underwritten life insurance policy simultaneously with your application for the Conversion policy. Underwritten policies are subject to underwriting requirements, so you may have to provide medical information. If you apply for both the Conversion policy and an underwritten policy and are approved for the underwritten policy, then you can choose the underwritten policy. If you are not approved for the underwritten policy, then the Conversion policy will be issued and become effective on the 32nd day after your group coverage ends.

Portability or porting is an optional feature chosen by your former employer. It allows you and your dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate policy. Once enrolled, MetLife will mail you a portable certificate and your initial bill. Instructions on how to set up the monthly Electronic Funds Transfer (EFT) can be found on the back of your bill. If you apply for Portability, preferred portable rates are available for you and your spouse or domestic partner with Evidence of Insurability (EOI). Portable coverage is effective on the 32nd day after group coverage ends.

WHAT IF I STILL HAVE QUESTIONS?

Helping you make the best decision for you and your family's needs is important to us. If you have additional questions or need assistance, please contact the following MetLife customer service areas:

To speak with a MetLife representative who can answer questions about Portability, call **1-888-252-3607**.

To be connected with a MetLife representative who can answer questions about Conversion, call **1-877-275-6387**.

The information contained in this document is not intended to (and cannot) be used by anyone to avoid IRS penalties. This document supports the promotion and marketing of insurance products. Employees should seek advice based on their particular circumstances from an independent tax advisor since any discussion of taxes is for general informational purposes only and does not purport to be complete or cover every situation.

MetLife

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Understanding your Options

Portability and Conversion

MetLife



IT'S IMPORTANT TO UNDERSTAND THE DIFFERENCES BETWEEN THESE OPTIONS. USE THE CHART BELOW TO HELP YOU MAKE AN INFORMED DECISION.

	PORTABILITY ¹	CONVERSION
<p>What are the basics of each option?</p>	<p>You can continue your Group Life and AD&D* insurance coverage with MetLife if your coverage terminates in whole or in part due to:</p> <p>Employee Qualifying Events:</p> <ul style="list-style-type: none"> • Termination of employment or retirement • A change in your employee class • Your Group Policy is amended to end coverage, unless coverage is replaced by a similar insurance under another group insurance policy • Your Group policy ends with or without a successor plan • Reduced coverage due to age or change in plan for your employee class <p>Dependent Qualifying Events:</p> <ul style="list-style-type: none"> • Employee is eligible to exercise portability option • Spouse can port upon the Death of the Employee, Divorce, Annulment, Civil Union or Reciprocal Beneficiary relationship ends • Dependent no longer eligible as a Dependent <p>You are not eligible for Portability if you received approval for Premium Waiver Death Benefits. *Your plan may not include the Portability feature on every product presented on the Election of Portable Coverage Form. The Recordkeeper for your plan will identify which coverage(s) and coverage amount(s) you are eligible to port.²</p>	<p>You can generally convert your Group Life insurance benefits to an Individual Whole Life insurance policy⁵ if your coverage terminates in whole or in part due to:</p> <ul style="list-style-type: none"> • Retirement or termination of employment • A change in your employee class <p>Conversion is available on all Group Life insurance coverages. Conversion is not available on AD&D coverage.</p>
<p>Does coverage reduce or terminate?</p>	<ul style="list-style-type: none"> • Employee: Reduces 50% at age 70, and terminates at age 100. • Spouse: Terminates at age 70. • Child(ren): Terminates at age 25. At age 25, each child may apply to continue their portable coverage by completing a NewPort election form. They will also have the option to apply for Preferred Life Rates (lower preferred rates). 	<p>Coverage reductions and termination are subject to the terms of the policy chosen.</p>
<p>Will I have to answer medical questions?</p>	<p>No. However, medical questions must be answered to apply for Preferred Life Rates (lower preferred rates). If approved by MetLife, you will be billed using the Preferred Life Rates (lower preferred rates).</p>	<p>No.</p>
<p>What are the minimum and maximum amounts of coverage?</p>	<p>The standard coverage minimum amounts are:</p> <ul style="list-style-type: none"> • \$10,000 for employees • \$2,500 for spouses • \$10,000 for Spouse Only (no portable employee coverage) • \$1,000 for children <p>Your coverage maximum amount is generally limited to the amount you had at the time group benefits terminated and may vary, depending on the type of coverage you had. The standard maximum coverage amount is \$2 million. Details about your specific coverage can be found on the Election of Portable Coverage form.</p>	<p>The coverage minimum under Conversion is subject to the Individual Life plan features. The maximum coverage amount under Conversion varies based on the following:</p> <ul style="list-style-type: none"> • The reason group benefits ended. • The amount of group insurance you have. • Your eligibility for any other group benefits within 31 days after current benefits terminate. • Specific state regulations.
<p>Can I increase or decrease coverage amounts after the initial application period?</p>	<p>Coverage can be increased in \$25,000 increments up to \$250,000 with Evidence of Insurability (EOI) at the initial application and annually at the insured's portability anniversary date. Portable coverage may also be decreased, as needed.</p>	<p>Coverage cannot be increased at any time and cannot be decreased on Whole Life policies.</p>
<p>What additional features/services are available?</p>	<ul style="list-style-type: none"> • Accelerated Benefits Option (ABO) for Life coverage(s) only.³ • Total Control Account® (TCA) for beneficiaries.⁴ 	<p>Total Control Account® (TCA) for beneficiaries.⁴</p>
<p>How do I enroll/apply for coverage?</p>	<ul style="list-style-type: none"> • You will receive an Election of Portable Coverage form from your Group Life Benefits Recordkeeper. • You have 31 days from the date on the Election form to complete and return this form to MetLife. • Coverage will take effect 32 days after your group coverage ends. 	<ul style="list-style-type: none"> • You will receive a Notice of Conversion form from your Group Life Benefits Recordkeeper. • You have 31 days from the date your coverage ends to contact MetLife to convert your coverage. You must contact MetLife within this 31-day period to begin the conversion process. • A MetLife agent will consult with you on your specific needs and assist you with the application process.
<p>Will the rates be different from the rates I paid while I was working?</p>	<ul style="list-style-type: none"> • Rates are based on your current age and differ from the rates you paid while employed. As with any group of insureds, rates may change based on the financial experience of the group. • MetLife will bill you monthly for your coverage. The option to make monthly payments via Electronic Funds Transfer is available by contacting MetLife at 1-888-252-3607. • There is a \$1 administrative fee added to each monthly premium if Employee Life coverage is \$20,000 or more. If Employee Life coverage is less than \$20,000, the monthly administrative fee is \$3. The monthly administrative fee is waived for insureds who use Electronic Funds Transfer. • Employee or Spouse can apply for Preferred Life (lower preferred rates) premium rates by answering medical questions. If not approved, Employee and Spouse can still participate in portable coverage at the Non-Preferred (higher) premium rates. 	<ul style="list-style-type: none"> • Rates for Conversion are based on your age at the time you convert your coverage and remain level throughout the life of the policy. • The MetLife agent will discuss your payment options with you.

¹ Subject to state availability. To take advantage of this benefit, coverage of at least \$10,000 must be elected. Increases, decreases, minimum and maximum coverage amounts are subject to state availability.

² You may later convert ported coverage when ported benefits end, or if the portable plan is terminated by MetLife. Conversion is not available on AD&D coverage. Conversion rates are based on your age at the time you convert.

³ When life expectancy is certified by a physician to be 12 months (24 months in IL, TX or WA) or less. The Accelerated Benefits Option (ABO) is subject to state availability and regulation. The ABO benefits are intended to qualify for favorable federal tax treatment, in which case the benefits will not be subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of ABO benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of ABO benefits will have on public assistance eligibility for you, your spouse or your family.

⁴ Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of \$5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims-paying ability of MetLife.

⁵ A non-renewable term life policy may precede a whole life conversion policy if your group coverage is issued in New York or West Virginia.



How You Can Continue Your Group Term Life Insurance – (Portability)

What is Portability?

Portability or porting is an optional feature chosen by your former employer. It allows employees and dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate group policy. The attached medical questions (Statement of Health Form) do not need to be answered to enroll, however you or your spouse/domestic partner must complete them in order to apply for Preferred Life Rates (lower). If approved by MetLife, you will be billed using the Preferred Life Rates (lower).

- If you do not complete the medical questions or do not satisfy MetLife's underwriting requirements, portable coverage will still be issued based on the Non-Preferred Rates (higher).

Once enrolled MetLife will mail you a portable certificate and your initial bill including instructions on how to set up the monthly Electronic Funds Transfer (EFT). The instructions to set up EFT can be found on the back of your bill.

- Your first bill will also include any retroactive premium due from the effective date of your portable coverage and an administrative fee. The current administrative fee is \$1.00 per statement if your total portable life insurance coverage is \$20,000 or more and \$3.00 per statement if your total portable life insurance coverage is less than \$20,000. If you only port dependent term life or AD&D, regardless of the amount of coverage, your administrative fee will be \$3.00 per statement. If you enroll for EFT the monthly administrative fee is no longer charged

Why is Portable Coverage Important?

Portable coverage provides security and helps eliminate gaps in coverage that you may experience during a time of transition, even if your employment ends.

How Much Time Do I Have To Elect Portability?

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is within 15 days after your coverage ends or is reduced, you will have 31 days after your coverage ended to enroll.

Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 8	August 31	September 1
July 31	August 15	August 31	September 1

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is given more than 15 days after your coverage ended or is reduced, you will have 45 from the Date of This Notice to enroll.

Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 16	September 30	September 1
July 31	August 23	October 7	September 1

- Under **no** circumstances will the option to port be extended past 91 days after the date coverage ended under your former employer's plan.

How Do I Enroll For Portable Life And AD&D Insurance Coverage For Myself And My Dependents?

1. Complete Part B beginning on page 1 of the attached Election of Portable Coverage Form and be sure to answer all sections.
2. Complete the enclosed medical questions (Statement of Health Form) only if:
 - a) You are applying for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner; or
 - b) You wish to increase the amount of life insurance that you previously had under your former employer's plan, either for yourself, your Spouse/Domestic Partner, or both.
3. Complete, sign and date the Designation of Beneficiary for Your Life Benefits (Part C of the attached Election of Portable Coverage Form).

What Needs To Be Mailed To Complete My Enrollment?

You must return:

- a) Your Election of Portable Coverage Form, including information for yourself and if applicable your spouse/domestic partner and child(ren) (Part A and Part B); and
- b) Designation of Beneficiary for Your Life Benefits (Part C)

If you are also **applying** for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner or wish to **increase** your or your Spouse/Domestic Partner's amount of life insurance you must also return the medical questions (Statement of Health) for each person.

- This mailing only contains one set of medical questions (Statement of Health Form). If the medical questions need to be completed for more than one individual, you may make a copy prior to completing or you may call the MetLife Customer Service Center for an additional set of medical questions.

Mail all correspondence to:
MetLife Recordkeeping and Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Or Fax to: 1-866-545-7517

Please Note: Certain benefits and provisions that were available under the employer's group policy will no longer be applicable or may be different under your portable coverage.

For questions or assistance, contact the MetLife Customer Service Center toll-free at 1-888-252-3607, Monday – Friday between the hours of 8:00 a.m. and 11:00 p.m. (EST).



ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is the party designated to maintain records of coverage in effect prior to the Employee becoming eligible to Port. The Recordkeeper may be the Employer, a Third Party Administrator (TPA) or MetLife.)

1. Immediately upon the Employee's eligibility for Portability, complete Part A below and Column 1 of the table on page 2 and then make a copy of this form.
2. If the Reason for the Portability Eligibility is Death of the Employee or Divorce, complete all of the fields in Part A below with the Spouse/Domestic Partner's information, not the Employee's information. In the column for Amount of Insurance Terminated or Reduced, leave the Employee amounts blank and enter the Dependent Spouse/Domestic Partner/Domestic Partner and Dependent Child(ren) amounts as applicable.
3. Provide the Employee (or Spouse/Domestic Partner in the event of Death of the Employee or Divorce) with the original or mail it to their last known address.
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER		Date of This Notice (ex. MM/DD/YYYY):
Employer's Name:		Group Customer No.:
Employee Name: (First, Middle, Last)		Date Coverage Ended or was Reduced:
Employee's Mailing Address: (Street, City, State Zip)		
Has coverage been assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify coverage assigned _____ and attach a copy of assignment form. If coverage has been assigned this form must be mailed to the owner.		
Employee's Basic Annual Earnings: \$	Reason for Insured's Portability Eligibility:	
Recordkeeper's Name:		
Print name of person at Recordkeeper completing Part A:		Telephone Number:

Part B – TO BE COMPLETED BY THE EMPLOYEE		
Employee's Home Email Address:		Employee's Home Telephone No.:
Social Security Number:	Date of Birth: (ex. MM/DD/YYYY)	Sex (M/F):
Note: If you answer Yes to any of the questions below medical questions (Statement of Health Form) must be completed for each person. This mailing only includes one set of medical questions. They may be copied or you may call the MetLife Customer Service Center number for an additional set of medical questions.		
Are you applying for Preferred Life Rates (lower) for yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you applying for Preferred Life Rates (lower) for your Spouse/Domestic Partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you requesting an increase in Life Insurance coverage for yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you requesting an increase in Life Insurance coverage for your Spouse/Domestic Partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM

To be Completed by the Recordkeeper (Shaded areas to be completed by the Recordkeeper).		To be Completed by the Employee (For each Type of Coverage, please indicate whether you want to continue, discontinue, increase, or decrease the amount of insurance in the shaded column. Select just one option for each Type of Coverage).			
		Continue coverage	Discontinue coverage	Increase coverage	Decrease coverage
Type of Coverage	Amount of Insurance Terminated or Reduced Insert the actual \$\$ amount of coverage (i.e. \$50,000)	I want to <u>continue</u> the same amount of insurance in the shaded column.	I want to <u>discontinue</u> the insurance in the shaded column.	I want to <u>increase</u> my insurance in the shaded column by the following amount. ¹ (Ex. \$25,000 means you want to increase your insurance amount in column 1 by \$25,000).	I want to <u>decrease</u> my insurance in the shaded column by the following amount. (Ex. \$30,000 means you want to decrease your insurance amount in column 1 by \$30,000).

Employee^{2,3}

Basic Life	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Basic AD&D ⁴	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Supplemental/Optional Life	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Supplemental/Optional AD&D ⁴	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Voluntary AD&D ⁴	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Dependents					

Dependent Spouse/Domestic Partner^{2,3,5}

Dependent Life	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Dependent AD&D ⁴	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Voluntary AD&D ^{4,6}	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____

Dependent Child(ren)^{3,5}

Dependent Life	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Dependent AD&D ⁴	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____
Voluntary AD&D ^{4,6}	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	– \$ _____

¹ Increases in coverage are available annually and must be in \$25,000 increments up to \$250,000. For a life insurance increase the employee must complete the medical questions and be approved by MetLife. An increase in AD&D coverage only does not require the insured to complete medical questions.

² The maximum amount the employee can continue on a portable basis is \$2,000,000. The maximum amount the spouse/domestic partner can continue on a portable basis is \$250,000.

³ In order to port coverage for yourself or your dependents, you must have had that coverage under your former plan at the time of your coverage termination.

⁴ AD&D coverage is available without Life Insurance coverage.

⁵ Subject to state limits, the Dependent Spouse/Domestic Partner amount can be greater than the Employee Amount. For Employee and Spouse/Domestic Partner coverage: Spouse/Domestic Partner minimum is \$2,500. For Spouse/Domestic Partner only coverage: Spouse/Domestic Partner minimum is \$10,000. The Child minimum is \$1,000.

⁶ Use these fields only when Voluntary AD&D is being requested for the Spouse/Domestic Partner and/or Child because of the death of the Employee or divorce.

NOTE: All coverage amounts are subject to applicable state laws.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM – TO BE COMPLETED BY EMPLOYEE

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attached a separate sheet of paper, sign and date)				
Dependent	Name (First, Middle, Last)	SSN	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Spouse/Domestic Partner				
Child				
Child				
Child				

Part C – TO BE COMPLETED BY THE EMPLOYEE

DESIGNATION OF BENEFICIARY FOR YOUR LIFE INSURANCE (Dependent Life Insurance is payable as specified in the Certificate)

Only check one of the following boxes.

- I designate the following person(s) as my primary beneficiary(ies) for my portable term coverage(s). With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
- My designation of beneficiary is on a separate form which is signed, dated and attached.

The amount of insurance that is paid to you or your beneficiary will be decreased by any amount of contribution owed to MetLife.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL:** 100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. **TOTAL:** 100%

FRAUD WARNING

Before signing this election form, please read the warning below:

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

DECLARATION AND SIGNATURE

- The person signing below acknowledges that they have read and understand the statements and declarations made in this election form.
- The person signing below acknowledges that they have read the Fraud Warning provided in this election form.



Signature of Insured/Owner



Date Signed (MM/DD/YYYY)

Please Note: MetLife needs to receive the original. The signature and date above may not be altered.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

**TABLE A
LIFE INSURANCE ONLY PREFERRED MONTHLY TERM RATES**

RATE SHEET
Schedule of Monthly Portable Preferred Group Life Insurance Term Rates
For Insured and Dependent Spouse/Domestic Partner

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\$50,000 \div \$1,000 = 50 \times \$0.150 = \$7.50 + \$1.00 = \$8.50$$

Amount of coverage selected \div \$1,000 = # of units \times Rate based on age 45 = Monthly insurance premium $+$ Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.050	\$0.050
16	\$0.050	\$0.050
17	\$0.050	\$0.050
18	\$0.050	\$0.050
19	\$0.050	\$0.050
20	\$0.050	\$0.050
21	\$0.050	\$0.050
22	\$0.050	\$0.050
23	\$0.050	\$0.050
24	\$0.050	\$0.050
25	\$0.060	\$0.060
26	\$0.060	\$0.060
27	\$0.060	\$0.060
28	\$0.060	\$0.060
29	\$0.060	\$0.060
30	\$0.080	\$0.080
31	\$0.080	\$0.080
32	\$0.080	\$0.080
33	\$0.080	\$0.080
34	\$0.080	\$0.080
35	\$0.090	\$0.090
36	\$0.090	\$0.090
37	\$0.090	\$0.090
38	\$0.090	\$0.090
39	\$0.090	\$0.090
40	\$0.100	\$0.100
41	\$0.108	\$0.108
42	\$0.118	\$0.118
43	\$0.128	\$0.128

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.138	\$0.138
45	\$0.150	\$0.150
46	\$0.163	\$0.163
47	\$0.178	\$0.178
48	\$0.194	\$0.194
49	\$0.211	\$0.211
50	\$0.230	\$0.230
51	\$0.261	\$0.261
52	\$0.295	\$0.295
53	\$0.335	\$0.335
54	\$0.379	\$0.379
55	\$0.430	\$0.430
56	\$0.468	\$0.468
57	\$0.510	\$0.510
58	\$0.556	\$0.556
59	\$0.606	\$0.606
60	\$0.660	\$0.660
61	\$0.752	\$0.752
62	\$0.858	\$0.858
63	\$0.977	\$0.977
64	\$1.114	\$1.114
65	\$1.270	\$1.270
66	\$1.399	\$1.399
67	\$1.541	\$1.541
68	\$1.698	\$1.698
69	\$1.870	\$1.870
70	\$2.060	N/A
71	\$2.228	N/A
72	\$2.409	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$2.605	N/A
74	\$2.818	N/A
75	\$3.047	N/A
76	\$3.295	N/A
77	\$3.564	N/A
78	\$3.854	N/A
79	\$4.168	N/A
80	\$4.460	N/A
81	\$4.910	N/A
82	\$5.410	N/A
83	\$5.960	N/A
84	\$6.560	N/A
85	\$7.220	N/A
86	\$7.950	N/A
87	\$8.760	N/A
88	\$9.650	N/A
89	\$10.630	N/A
90	\$11.710	N/A
91	\$12.900	N/A
92	\$14.190	N/A
93	\$15.630	N/A
94	\$17.210	N/A
95	\$18.950	N/A
96	\$20.870	N/A
97	\$22.990	N/A
98	\$25.320	N/A
99	\$27.880	N/A

**TABLE B
LIFE INSURANCE ONLY NON-PREFERRED MONTHLY TERM RATES**

RATE SHEET
Schedule of Monthly Portable Non-Preferred Group Life Insurance Term Rates
For Insured and Dependent Spouse/Domestic Partner

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\$50,000 \div \$1,000 = 50 \times \$0.538 = \$26.90 + \$1.00 = \$27.90$$

Amount of coverage selected \div \$1,000 = # of units \times Rate based on age 45 = Monthly insurance premium $+$ Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.162	\$0.162
16	\$0.190	\$0.190
17	\$0.208	\$0.208
18	\$0.224	\$0.224
19	\$0.232	\$0.232
20	\$0.234	\$0.234
21	\$0.256	\$0.256
22	\$0.242	\$0.242
23	\$0.202	\$0.202
24	\$0.184	\$0.184
25	\$0.170	\$0.170
26	\$0.170	\$0.170
27	\$0.154	\$0.154
28	\$0.150	\$0.150
29	\$0.146	\$0.146
30	\$0.142	\$0.142
31	\$0.138	\$0.138
32	\$0.150	\$0.150
33	\$0.148	\$0.148
34	\$0.160	\$0.160
35	\$0.176	\$0.176
36	\$0.188	\$0.188
37	\$0.216	\$0.216
38	\$0.244	\$0.244
39	\$0.274	\$0.274
40	\$0.308	\$0.308
41	\$0.350	\$0.350
42	\$0.396	\$0.396
43	\$0.440	\$0.440

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.484	\$0.484
45	\$0.538	\$0.538
46	\$0.600	\$0.600
47	\$0.670	\$0.670
48	\$0.742	\$0.742
49	\$0.818	\$0.818
50	\$0.906	\$0.906
51	\$1.006	\$1.006
52	\$1.116	\$1.116
53	\$1.216	\$1.216
54	\$1.312	\$1.312
55	\$1.442	\$1.442
56	\$1.584	\$1.584
57	\$1.752	\$1.752
58	\$1.932	\$1.932
59	\$2.134	\$2.134
60	\$2.372	\$2.372
61	\$2.634	\$2.634
62	\$2.932	\$2.932
63	\$3.192	\$3.192
64	\$3.500	\$3.500
65	\$3.846	\$3.846
66	\$4.216	\$4.216
67	\$4.538	\$4.538
68	\$4.850	\$4.850
69	\$5.212	\$5.212
70	\$5.638	N/A
71	\$6.142	N/A
72	\$6.740	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$7.340	N/A
74	\$8.012	N/A
75	\$8.742	N/A
76	\$9.634	N/A
77	\$10.576	N/A
78	\$11.416	N/A
79	\$12.356	N/A
80	\$13.564	N/A
81	\$14.806	N/A
82	\$16.234	N/A
83	\$17.844	N/A
84	\$19.202	N/A
85	\$20.573	N/A
86	\$22.137	N/A
87	\$23.932	N/A
88	\$25.745	N/A
89	\$27.876	N/A
90	\$30.427	N/A
91	\$31.876	N/A
92	\$34.257	N/A
93	\$37.304	N/A
94	\$39.972	N/A
95	\$42.821	N/A
96	\$45.858	N/A
97	\$49.095	N/A
98	\$52.551	N/A
99	\$55.858	N/A

**TABLE C
COMBINED LIFE & AD&D INSURANCE PREFERRED MONTHLY TERM RATES**

RATE SHEET
Schedule of Combined Monthly Portable Preferred Group Life and AD&D Insurance
Term Rates For Insured and Dependent Spouse/Domestic Partner

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\$50,000 \div \$1,000 = 50 \times \$0.185 = \$9.25 + \$1.00 = \$10.25$$

Amount of coverage selected \div \$1,000 = # of units \times Rate based on age 45 = Monthly insurance premium $+$ Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.085	\$0.075
16	\$0.085	\$0.075
17	\$0.085	\$0.075
18	\$0.085	\$0.075
19	\$0.085	\$0.075
20	\$0.085	\$0.075
21	\$0.085	\$0.075
22	\$0.085	\$0.075
23	\$0.085	\$0.075
24	\$0.085	\$0.075
25	\$0.095	\$0.085
26	\$0.095	\$0.085
27	\$0.095	\$0.085
28	\$0.095	\$0.085
29	\$0.095	\$0.085
30	\$0.115	\$0.105
31	\$0.115	\$0.105
32	\$0.115	\$0.105
33	\$0.115	\$0.105
34	\$0.115	\$0.105
35	\$0.125	\$0.115
36	\$0.125	\$0.115
37	\$0.125	\$0.115
38	\$0.125	\$0.115
39	\$0.125	\$0.115
40	\$0.135	\$0.125
41	\$0.143	\$0.133
42	\$0.153	\$0.143
43	\$0.163	\$0.153

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.173	\$0.163
45	\$0.185	\$0.175
46	\$0.198	\$0.188
47	\$0.213	\$0.203
48	\$0.229	\$0.219
49	\$0.246	\$0.236
50	\$0.265	\$0.255
51	\$0.296	\$0.286
52	\$0.330	\$0.320
53	\$0.370	\$0.360
54	\$0.414	\$0.404
55	\$0.465	\$0.455
56	\$0.503	\$0.493
57	\$0.545	\$0.535
58	\$0.591	\$0.581
59	\$0.641	\$0.631
60	\$0.695	\$0.685
61	\$0.787	\$0.777
62	\$0.893	\$0.883
63	\$1.012	\$1.002
64	\$1.149	\$1.139
65	\$1.305	\$1.295
66	\$1.434	\$1.424
67	\$1.576	\$1.566
68	\$1.733	\$1.723
69	\$1.905	\$1.895
70	\$2.095	N/A
71	\$2.263	N/A
72	\$2.444	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$2.640	N/A
74	\$2.853	N/A
75	\$3.082	N/A
76	\$3.330	N/A
77	\$3.599	N/A
78	\$3.889	N/A
79	\$4.203	N/A
80	\$4.495	N/A
81	\$4.945	N/A
82	\$5.445	N/A
83	\$5.995	N/A
84	\$6.595	N/A
85	\$7.255	N/A
86	\$7.985	N/A
87	\$8.795	N/A
88	\$9.685	N/A
89	\$10.665	N/A
90	\$11.745	N/A
91	\$12.935	N/A
92	\$14.225	N/A
93	\$15.665	N/A
94	\$17.245	N/A
95	\$18.985	N/A
96	\$20.905	N/A
97	\$23.025	N/A
98	\$25.355	N/A
99	\$27.915	N/A

**TABLE D
COMBINED LIFE & AD&D INSURANCE NON-PREFERRED MONTHLY TERM RATES**

**RATE SHEET
Schedule of Combined Monthly Portable Non-Preferred Group Life and AD&D Insurance Term Rates For Insured and Dependent Spouse/Domestic Partner**

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\$50,000 \div \$1,000 = 50 \times \$0.573 = \$28.65 + \$1.00 = \$29.65$$

Amount of coverage selected \div \$1,000 = # of units \times Rate based on age 45 = Monthly insurance premium $+$ Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.197	\$0.187
16	\$0.225	\$0.215
17	\$0.243	\$0.233
18	\$0.259	\$0.249
19	\$0.267	\$0.257
20	\$0.269	\$0.259
21	\$0.291	\$0.281
22	\$0.277	\$0.267
23	\$0.237	\$0.227
24	\$0.219	\$0.209
25	\$0.205	\$0.195
26	\$0.205	\$0.195
27	\$0.189	\$0.179
28	\$0.185	\$0.175
29	\$0.181	\$0.171
30	\$0.177	\$0.167
31	\$0.173	\$0.163
32	\$0.185	\$0.175
33	\$0.183	\$0.173
34	\$0.195	\$0.185
35	\$0.211	\$0.201
36	\$0.223	\$0.213
37	\$0.251	\$0.241
38	\$0.279	\$0.269
39	\$0.309	\$0.299
40	\$0.343	\$0.333
41	\$0.385	\$0.375
42	\$0.431	\$0.421
43	\$0.475	\$0.465

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.519	\$0.509
45	\$0.573	\$0.563
46	\$0.635	\$0.625
47	\$0.705	\$0.695
48	\$0.777	\$0.767
49	\$0.853	\$0.843
50	\$0.941	\$0.931
51	\$1.041	\$1.031
52	\$1.151	\$1.141
53	\$1.251	\$1.241
54	\$1.347	\$1.337
55	\$1.477	\$1.467
56	\$1.619	\$1.609
57	\$1.787	\$1.777
58	\$1.967	\$1.957
59	\$2.169	\$2.159
60	\$2.407	\$2.397
61	\$2.669	\$2.659
62	\$2.967	\$2.957
63	\$3.227	\$3.217
64	\$3.535	\$3.525
65	\$3.881	\$3.871
66	\$4.251	\$4.241
67	\$4.573	\$4.563
68	\$4.885	\$4.875
69	\$5.247	\$5.237
70	\$5.673	N/A
71	\$6.177	N/A
72	\$6.775	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$7.375	N/A
74	\$8.047	N/A
75	\$8.777	N/A
76	\$9.669	N/A
77	\$10.611	N/A
78	\$11.451	N/A
79	\$12.391	N/A
80	\$13.599	N/A
81	\$14.841	N/A
82	\$16.269	N/A
83	\$17.879	N/A
84	\$19.237	N/A
85	\$20.608	N/A
86	\$22.172	N/A
87	\$23.967	N/A
88	\$25.780	N/A
89	\$27.911	N/A
90	\$30.462	N/A
91	\$31.911	N/A
92	\$34.292	N/A
93	\$37.339	N/A
94	\$40.007	N/A
95	\$42.856	N/A
96	\$45.893	N/A
97	\$49.130	N/A
98	\$52.586	N/A
99	\$55.893	N/A

RATE SHEET
Schedule of Monthly Portable Group Life and AD&D Insurance Term Rates
For Insured and Dependents

TABLE E
CHILD MONTHLY TERM RATES

Table E – Sample monthly premium calculation for child(ren) only. An administrative fee will be not charged for the child coverage if you also port your term life insurance. However if only the child(ren) coverage is ported a \$3.00 per statement administrative fee will be charged.

$$\frac{\$10,000}{\$1,000} = 10 \times \$0.162 = \$1.62$$

Amount of coverage selected per child ÷ \$1,000 = # of units per child x Rate = Monthly premium

AGE	LIFE DEPENDENT CHILD(REN) RATE	COMBINED LIFE & AD&D DEPENDENT CHILD(REN) RATE
N/A	\$0.162	\$0.209

Please Note: Each child is covered for the same premium regardless of the number of children covered under the certificate. For instance, using the example above, if you have one child covered for \$10,000, the amount of premium per month is \$1.62. If you have 5 children, each child is covered for \$10,000, but the amount of premium per month is still \$1.62. A billing fee may also apply.

TABLE F
AD&D INSURANCE ONLY MONTHLY TERM RATES

Table F – Sample monthly premium calculation of AD&D Premium For Insured Only. An administrative fee will be not charged for AD&D coverage if you also port your term life insurance. However if only AD&D coverage is ported a \$3.00 per statement administrative fee will be charged.

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.035 = \$1.75$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate = Monthly premium

AD&D TERM RATES			VAD&D TERM RATES	
AD&D INSURED RATE	AD&D DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE	AD&D CHILD(REN) RATE	VAD&D INSURED ONLY RATE	VAD&D INSURED + DEPENDENTS RATE
\$0.035	\$0.025	\$0.047	\$0.035	\$0.050

INSTRUCTIONS

FOR THE STATEMENT OF HEALTH FORM AND THE AUTHORIZATION FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE EMPLOYEE

A Statement of Health Form is required if you are:

- Requesting Preferred Life Rates for you or your Dependent Spouse/Domestic Partner; or
- Applying for additional amounts of Life Insurance for you or your Dependent Spouse/Domestic Partner.

Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee or the Employee's Spouse/Domestic Partner.) A separate Statement of Health form must be completed by each Proposed Insured.

Based on the election form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. Complete the Statement of Health form and sign where indicated by an arrow.
2. Sign the Authorization form where indicated by an arrow.
3. After completion, make a copy of both completed forms for your records and MAIL the original forms to: ►

MetLife Recordkeeping and
Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoim@metlife.com.

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

MetLife

Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by MetLife)

Name of Group Customer/Employer/Association MetLife Group Life and Health Insurance Program Trust		Group Customer # 123470	Reporting Location #
Street Address 1314 King Street	City Wilmington	State Delaware	Zip Code 19801

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner		<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your name _____ Employee's Social Security/Identification # _____

1. Your height ___ feet ___ inches Your weight ___ pounds

2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____ Yes No

3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____ Yes No

4. Are you now, or have you in the past 5 years, used tobacco in any form? Yes No

5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Yes No

6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____" Yes No

7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? Yes No

8. Are you now receiving or applying for any disability benefits, including workers' compensation? Yes No

9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? Yes No

Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

a. cardiac or cardiovascular disorder? Yes No

b. stroke or circulatory disorder? Yes No

c. high blood pressure? Yes No

d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____ Yes No

e. anemia, leukemia or other blood disorder? Indicate type _____ Yes No

f. diabetes? Your age at diagnosis? ____ Check if insulin treated Yes No

g. asthma, COPD, emphysema or other lung disease? Indicate type _____ Yes No

h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ Yes No

i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ Yes No

j. memory loss? Yes No

k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____ Yes No

l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Yes No

m. multiple sclerosis, ALS or muscular dystrophy? Yes No

n. lupus, scleroderma, auto immune disease or connective tissue disorder? Yes No

o. arthritis? osteoarthritis rheumatoid other/type _____ Yes No

p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Yes No

q. carpal tunnel syndrome? Yes No

r. kidney, urinary tract or prostate disorder? Indicate type _____ Yes No

s. thyroid or other gland disorder? Indicate type _____ Yes No

t. mental, anxiety, depression, attempted suicide or nervous disorder? Yes No

u. sleep apnea Yes No

For "yes" answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are answered "no," you may proceed directly to Section 3 on the next page.

SECTION 2 – Please provide full details-below for each “Yes” answer to the preceding questions 1- 11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

Question Number	Condition/Diagnosis	Medication Prescribed <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street City State Zip Code		
Telephone: () - _____		

Question Number	Condition/Diagnosis	Medication Prescribed <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street City State Zip Code		
Telephone: () - _____		

Question Number	Condition/Diagnosis	Medication Prescribed <input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street City State Zip Code		
Telephone: () - _____		

SECTION 3

1. Personal Physician's Name: _____ Telephone: () - _____
Address (Street, City, State, Zip Code): _____
Date of last visit (MM/DD/YYYY): _____ Reason for visit: _____
2. Are you currently taking any other prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication: _____ Condition/Diagnosis: _____
Prescribing Physician's Name: _____ Telephone: () - _____
Address (Street, City, State, Zip Code): _____

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.



_____ Signature of Proposed Insured	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
--	---------------------	-----------------------------------

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured.** A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.



_____ Signature of Personal Representative	_____ Print Name	_____ Date Signed (MM/DD/YYYY)
_____ Relationship of Personal Representative		

GEF09-1
DEC

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at [P.O. Box 14069, Lexington, KY 40512-4069,] and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.



_____ Signature of Employee	_____ Date Signed (Mo./Day/Yr.)
_____ Print Name	_____ State of Birth
_____ Country of Birth	



_____ Signature of Spouse	_____ Date Signed (Mo./Day/Yr.)
_____ Print Name	_____ State of Birth
_____ Country of Birth	



Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.