


Group Operations  
Metropolitan Life Insurance Company

[Date]

[Name]  
[Address]  
[City, State Zip]

 Time-sensitive action required if you want to continue your coverage.

**Dear [Name],**

### Why we're contacting you

You have MetLife group life insurance benefits provided to you by [Company Name]. Effective [Date], some or all of those life insurance benefits will change. However, if you act now, you have options to continue your coverage. Those options are described in the "Additional Information" section of this letter. You can also find details about your coverage, and the amount eligible to continue listed in the table on page 2.

### What you need to know

Your options include the conversion of your coverage to an individual policy or porting your coverage. We want to help you understand the options available to you. MetLife has an arrangement with Barnum Financial Group and their associated third party financial professionals to offer you advice on the best option for you. You may receive a call from a specially trained Barnum Financial Group associated third party financial professional who can answer any questions you may have or possibly identify other lower-cost alternatives.

### What you need to do

Please read the enclosed **Conversion Notice**. It provides:

- The timeline for conversion.
- Details about the amount and types of coverage you can convert.

For information on your Portability options, read the Additional Information section of this letter and the enclosed **Election of Portable Coverage form**.

You must elect Conversion or Portability before the deadline in your Conversion Notice / Election of Portable Coverage if you would like to continue your insurance coverage.

### What will happen if we don't hear from you

If you do not respond, the election period will end and you will lose the chance to continue your coverage without a medical exam.

### We're here to help

You can contact us to arrange for a third party financial professional from Barnum Financial Group to contact you directly. You can reach us at 1-877-275-6387 Monday – Friday from 9:00 a.m. to 6:00 p.m. Eastern time.



Visit [metlife.com/change](https://www.metlife.com/change) to find more information, and arrange to have a financial professional contact you.

Sincerely,  
MetLife Transition Solutions

**Enclosure(s):** Conversion notice, Election of Portable Coverage form

## Additional information

Your benefits may have changed because:

- You no longer work for your employer (this includes retirement).
- There was a scheduled decrease or end of coverage.
- Your dependent spouse's or child's eligibility changed (e.g., child reached the plan's age limit, death of employee, divorce or termination of domestic partnership).
- The employee class or plan eligibility changed.
- The group policy ended.

## Conversion option

When you "convert" your group coverage, that coverage ends and you have the option to start an individual life insurance policy in the same or a lesser amount. We'll issue your individual policy without a medical examination, as long as you complete the required forms and pay the premium within the election period. You cannot convert Accidental Death & Dismemberment coverage.

## Portability option

When you "port" group insurance, you can continue your group term life coverage without a medical exam by paying any future premiums directly to MetLife. You can also purchase more coverage or apply for preferred rates by answering medical questions. If you reside outside the U.S., you are not eligible to apply for preferred rates or additional coverage. There is a \$2,000,000 limit on coverage you can port. You cannot port any coverage above that maximum. If you decide to port, you can convert any remaining amount above that maximum to an individual policy. Once you port your coverage, you are covered under a new group policy.

If you would like to port your coverage, read the instructions carefully, then complete and sign the enclosed Election of Portable Coverage form. If you have any questions about your portability options or election process, you can call MetLife Portability at the number listed on your Portability paperwork.

The table below outlines your life insurance conversion and portability options:

<b>Coverage type</b>	<b>Eligible conversion amount</b>	<b>Eligible portability amount</b>
Basic Life	\$50,000	N/A
Optional Life	\$250,000	\$250,000
Spouse Dependent Life	\$0	\$0
Child Dependent Life	\$0	\$0
Optional Accidental Death and Dismemberment	N/A	\$250,000
Dependent Spouse Accidental Death and Dismemberment	N/A	\$0
Dependent Child Accidental Death and Dismemberment	N/A	\$0

Metropolitan Life Insurance Company (MetLife), New York, NY 10166.

Like most insurance policies and benefit programs, insurance policies and benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, waiting periods, reductions of benefits, limitations and terms for keeping them in force. Please contact MetLife for complete details.

MetLife administers the Transition Solutions program, but has arranged for specially-trained third party financial professionals to offer financial education and, upon request, provide personal guidance to employees and former employees of companies providing Transition Solutions through MetLife.

## Notice of Group Life Insurance Conversion Privilege

Metropolitan Life Insurance Company, New York, NY

*This Notice is not a conversion application or policy. Follow the instructions in this Notice if you would like to convert your group coverage.*

### Instructions

#### Instructions to policyholder/recordkeeper:

Complete this Notice and provide a copy to the employee when group coverage terminates. If coverage has been assigned, provide notice to the Assignee.

#### Instructions to eligible person:

You may convert your coverage to an individual life insurance policy, which will be issued without medical examination if you apply for it and pay the required premium within the application period.

#### Application period:

The application period is based on the date your group coverage terminates and the date of this Notice. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if this Notice is dated more than 15 days from date of termination, your application period is extended for an additional 15 days from the date of this Notice. If the 15-day extension applies to you, it will not exceed more than 91 days from the date group insurance was terminated.

The conversion application period is time-sensitive. If you are interested in converting your group coverage, you can meet with a specially-trained financial professional and complete an application. MetLife has an arrangement for third party financial professionals to explain your options. Call us at 877-275-6387 to arrange for a third party financial professional to contact you directly.

### Eligible person / Employee information

Date of this Notice ( <i>mm/dd/yyyy</i> )	Date Group Coverage terminates or reduces ( <i>mm/dd/yyyy</i> )
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#### Insured

First name	Middle name	Last name
Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Dependent	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )

#### Owner *If certificate is assigned*

First name	Middle name	Last name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	

#### Dependent *If applicable*

First name	Middle name	Last name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ( <i>mm/dd/yyyy</i> )	

Address of Insured/Owner	City	State	ZIP
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Phone number

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Date Group Life benefits became effective for insured (mm/dd/yyyy)

Reason for termination:  Termination of employment  Termination of Group Policy or Class  
 Retirement  No longer an eligible dependent  Total Disability

### Coverage Information

Complete the relevant column based on the event triggering conversion.  
If an accelerated benefits option claim was paid, reduce the amount available for conversion by the ABO claim amount.

If coverage is ending due to termination of employment or eligibility, or is reducing, complete the applicable fields below.

If the group policy or a class under the policy is ending, complete the applicable fields below. The amount of coverage available for conversion is the lesser of the amount lost, or \$10,000, provided the insured was covered under the plan for at least five years.

Coverage type	Group Policy report number	Coverage amount	Coverage amount. Cannot exceed \$10,000
Basic Life		\$ 50,000	N/A
Supplemental Life		\$ 250,000	N/A
Dependent Spouse Life		\$	\$0
Dependent Child Life		\$	\$0
Group Universal Life		\$	
Group Variable Universal Life		\$	
Survivor		\$	N/A

### Group Policyholder

Name

Address	City	State	ZIP
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Phone number

### Authorized Group Policyholder representative (print)

Name

**MetLife Transition Solutions**



Metropolitan Life Insurance Company, New York, NY 10166

## 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 7	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 days 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 22	October 6	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:

**Metropolitan Life Insurance Company**  
**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.

**MN Residents** - Please contact our MetLife Customer Service Center at the toll free number below to receive a copy of your state specific schedule of rates.

**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).**



Metropolitan Life Insurance Company, New York, NY 10166

## 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.

<b>Part A – TO BE COMPLETED BY THE RECORDKEEPER</b>		<b>Date of This Notice (ex. MM/DD/YYYY):</b>
<b>Employer's Name:</b>		<b>Group Customer No.:</b>
<b>Employee Name: (First, Middle, Last)</b>		<b>Date Coverage Ended or was Reduced:</b>
<b>Employee's Mailing Address: (Street, City, State Zip)</b>		
<b>Has coverage been assigned?</b> [ ] Yes [ ] 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.		
<b>Employee's Basic Annual Earnings:</b> \$		<b>Reason for Insured's Portability Eligibility:</b>
<b>Recordkeeper's Name:</b> MetLife Transition Solutions		
<b>Print name of person at Recordkeeper completing Part A:</b> MetLife Transition Solutions		<b>Telephone Number:</b> 1-888-252-3607

<b>Part B – TO BE COMPLETED BY THE EMPLOYEE</b>		
<b>Employee's Home Email Address:</b>		<b>Employee's Home Telephone No.:</b>
<b>Social Security Number:</b>	<b>Date of Birth: (ex. MM/DD/YYYY)</b>	<b>Sex (M/F):</b>
<b>Note:</b> 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**

<b>To be Completed by the Recordkeeper</b> (Shaded areas to be completed by the Recordkeeper).		<b>To be Completed by the Employee</b> (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).			
		<b>Continue coverage</b>	<b>Discontinue coverage</b>	<b>Increase coverage</b>	<b>Decrease coverage</b>
<b>Type of Coverage</b>	<b>Amount of Insurance Terminated or Reduced</b> 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. <sup>1</sup> (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).

<b>Employee<sup>2,3</sup></b>					
Basic Life	\$Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Basic AD&D <sup>4</sup>	\$Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Supplemental/Optional Life	\$250,000	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Supplemental/Optional AD&D <sup>4</sup>	\$250,000	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Voluntary AD&D <sup>4</sup>	\$Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Dependents					

<b>Dependent Spouse/Domestic Partner<sup>2,3,5</sup></b>					
Dependent Life	\$0	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Dependent AD&D <sup>4</sup>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Voluntary AD&D <sup>4,6</sup>	\$Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____

<b>Dependent Child(ren)<sup>3,5</sup></b>					
Dependent Life	\$0	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Dependent AD&D <sup>4</sup>	\$0	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____
Voluntary AD&D <sup>4,6</sup>	\$Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>	+ \$ _____	- \$ _____

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> 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.
- <sup>4</sup> AD&D coverage is available without Life Insurance coverage.
- <sup>5</sup> 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.
- <sup>6</sup> 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, attach 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				

**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 **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 to the extent required by applicable law.

**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.

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

**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 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 Insurance):** 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.

**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.

**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.

**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.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**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.

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 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 #:	
<b>Payment will be made in equal shares or all to the survivor unless otherwise indicated.</b>			<b>TOTAL:</b>	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 #:	
<b>Payment will be made in equal shares or all to the survivor unless otherwise indicated.</b>			<b>TOTAL:</b>	100%

**DECLARATION AND SIGNATURE**

The person signing below acknowledges that they have read and understand the statements and declarations made 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 31<sup>st</sup>, 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**

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.150 = \$7.50 + \$1.00 = \$8.50$$

Amount of coverage selected ÷ \$1,000 = # of units x 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 31<sup>st</sup>, 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**

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.538 = \$26.90 + \$1.00 = \$27.90$$

Amount of coverage selected ÷ \$1,000 = # of units x 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 31<sup>st</sup>, 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**

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.185 = \$9.25 + \$1.00 = \$10.25$$

Amount of coverage selected ÷ \$1,000 = # of units x 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 31<sup>st</sup>, 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**

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.573 = \$28.65 + \$1.00 = \$29.65$$

Amount of coverage selected ÷ \$1,000 = # of units x 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 not be 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 not be 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**

AD&D INSURED RATE	AD&D DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE	AD&D CHILD(REN) RATE
\$0.035	\$0.025	\$0.047

**VAD&D TERM RATES**

VAD&D INSURED ONLY RATE	VAD&D INSURED + DEPENDENTS RATE
\$0.035	\$0.050

## INSTRUCTIONS

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

### INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. 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 enrollment 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 FAX, MAIL or EMAIL the original forms to the address at the right.



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@metlifeservice.com](mailto:eoim@metlifeservice.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 coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.



Metropolitan Life Insurance Company, New York, NY 10166

## STATEMENT OF HEALTH FORM

### GROUP CUSTOMER INFORMATION

Name of Group Customer/Employer/Association <b>Trustee of the MetLife Group Life and Health Insurance Program Trust</b>		Group Customer # <b>123470</b>	
Street Address <b>500 Delaware Ave., 11<sup>th</sup> floor</b>	City <b>Wilmington</b>	State <b>Delaware</b>	Zip Code <b>19801</b>

### EMPLOYEE INFORMATION (To be Completed by the Employee)

Name of Employee (First, Middle, Last)	Social Security # of Employee
--	-------------------------------

### 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		

**GEF02-1  
ADM**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF02-1**

**ADM** applies to residents of Connecticut, North Dakota and Utah)

Please complete all sections of this form. Incomplete forms will be returned to you.

**Trustee of the MetLife Group Life and Health Insurance Program Trust**



**HEALTH INFORMATION**

**SECTION 1**

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. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

Your name \_\_\_\_\_ Employee's Name \_\_\_\_\_  
 Employee's Social Security/Identification # \_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 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 _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____<br>If "yes", provide Physician's name _____ Telephone: (    ) - _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now, or have you in the past 2 years, used tobacco in any form?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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) _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any application for life, accidental death and dismemberment or disability insurance <input type="checkbox"/> declined <input type="checkbox"/> postponed <input type="checkbox"/> withdrawn <input type="checkbox"/> rated <input type="checkbox"/> modified or <input type="checkbox"/> issued other than as applied for? Indicate reason _____                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now receiving or applying for any disability benefits, including workers' compensation?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been <b>Hospitalized</b> as defined below (not including well-baby delivery) in the past 90 days? <b>Hospitalized</b> 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. <b>For residents of all states except CT, please answer the following question:</b> Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>For CT residents, please answer the following question:</b> To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?   |                          |                          |
| 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? Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. stroke or circulatory disorder? Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. high blood pressure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. anemia, leukemia or other blood disorder? Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes? Your age at diagnosis? _____ <input type="checkbox"/> Check if insulin treated  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. asthma, COPD, emphysema or other lung disease? Indicate type _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. memory loss? Indicate type _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. epilepsy, paralysis, seizures, dizziness or other neurological disorder?<br>Specify date of last seizure (month/year) _____ Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| n. lupus, scleroderma, auto immune disease or connective tissue disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |

**GEF09-1**  
**HEA**  
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;  
**GEF09-1**  
**HEA** applies to residents of Connecticut, North Dakota and Utah)



Metropolitan Life Insurance Company, New York, NY 10166

- o. arthritis?  osteoarthritis  rheumatoid  other/type \_\_\_\_\_
- p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type \_\_\_\_\_
- q. carpal tunnel syndrome? \_\_\_\_\_
- r. kidney, urinary tract or prostate disorder? Indicate type \_\_\_\_\_
- s. thyroid or other gland disorder? Indicate type \_\_\_\_\_
- t. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type \_\_\_\_\_
- u. sleep apnea? Indicate type \_\_\_\_\_

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Personal Physician Information	
Personal Physician's Name: _____	
Address (Street, City, State, Zip Code): _____ Telephone: (    )    -	
Date of last visit (MM/DD/YYYY):    /    /                      Reason for visit: _____	

Prescription Information	
Are you currently taking any prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, list the medications.	
Medication: _____	Condition/Diagnosis: _____
Prescribing Physician's Name: _____ Telephone: (    )    -	
Address (Street, City, State, Zip Code): _____	
Medication: _____	Condition/Diagnosis: _____
Prescribing Physician's Name: _____ Telephone: (    )    -	
Address (Street, City, State, Zip Code): _____	
<input type="checkbox"/> Check here if you are attaching another sheet for any additional medications.	

SECTION 2
<b>Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1.</b> 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. <input type="checkbox"/> Check here if you are attaching another sheet.

Your name _____	Employee's Name _____
Your Date of Birth    /    /                      _____	

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State                      Zip Code
Telephone: (    )    - _____		

GEF09-1

HEA

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;

GEF09-1

HEA applies to residents of Connecticut, North Dakota and Utah)

Please complete all sections of this form. Incomplete forms will be returned to you.

Trustee of the MetLife Group Life and Health Insurance Program Trust



Metropolitan Life Insurance Company, New York, NY 10166

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.		
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment		
Treating Health Professional				
Physician's Name: _____				
Date of last visit: _____ Reason for visit: _____				
Address _____				
Street		City	State	Zip Code
Telephone: (    )    - _____				

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.		
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment		
Treating Health Professional				
Physician's Name: _____				
Date of last visit: _____ Reason for visit: _____				
Address _____				
Street		City	State	Zip Code
Telephone: (    )    - _____				

**GEF09-1**

**HEA**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1**

*HEA applies to residents of Connecticut, North Dakota and Utah)*

### 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 to the extent required by applicable law.

**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.

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

**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 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.

**GEF09-1**

**FW**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1**

*FW applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

**Trustee of the MetLife Group Life and Health Insurance Program Trust**

**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 Insurance): 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.

**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.

**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.

**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.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**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**

*(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;*

**GEF09-1**

*FW applies to residents of Connecticut, North Dakota and Utah)*

**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 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**

*(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;*

**GEF09-1**

*DEC applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

## 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.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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 (or his/her authorized representative) 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.

Sign Here

Signature of Proposed Insured	Date Signed (MM/DD/YYYY)
Print Name	State of Birth
	Country of Birth

If a child proposed for insurance is age 18 or over, the child must sign this Authorization form. 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.

Sign Here

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



**Delaware American Life Insurance Company**  
**Hyatt Legal Plans, Inc.**  
**Hyatt Legal Plans of Florida, Inc.**  
**MetLife Health Plans, Inc.**

**Metropolitan Life Insurance Company**  
**Metropolitan Tower Life Insurance Company**  
**SafeGuard Health Plans, Inc.**  
**SafeHealth Life Insurance Company**

**Our Privacy Notice**

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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.

**SECTION 1: 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, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

**SECTION 2: 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.

**SECTION 3: 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 legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

**SECTION 4: 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, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at [www.mib.com](http://www.mib.com).

**SECTION 5: 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

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## **SECTION 6: 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. We may share your personal information without your consent if 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

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## **SECTION 7: HIPAA**

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at [www.MetLife.com](http://www.MetLife.com). For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

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## **SECTION 8: 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 locatable and retrievable. 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 privileged information relating to 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.

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## **SECTION 9: Questions**

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. 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](mailto: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 the MetLife companies listed at the top of the first page.