MetLife®

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 to continue their Group Term Life insurance under a separate group policy. The attached medical questions (Statement of Health Form) do not need to be answered to enroll, however you 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 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 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 Insurance Coverage For Myself?

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
   b) You wish to increase the amount of life insurance that you previously had under your former employer's plan for yourself.

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 (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 wish to **increase** your amount of life insurance you must also return the medical questions (Statement of Health).

- 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).

MetLife®

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: **University of Miami**	**Group Customer No.:** **1164281**
Employee Name: (First, Middle, Last)	**Date Coverage Ended or was Reduced:**
Employee's Mailing Address: (Street, City, State Zip)	
Has coverage been assigned? ☐ 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.	
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?	☐ Yes ☐ No	
Are you requesting an increase in Life Insurance coverage for yourself?	☐ Yes ☐ 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 continue the same amount of insurance in the shaded column.	I want to discontinue the insurance in the shaded column.	I want to increase 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 decrease 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 [1,2]					
Supplemental/Optional Life	$_____	☐	☐	+ $_____	– $_____
Employee Only					

[1] 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.

[2] 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.

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 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%

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

Rates (cost per $1,000 of coverage per month) are based on the Insured'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	÷	$1,000	=	50	x	$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
15	$0.050
16	$0.050
17	$0.050
18	$0.050
19	$0.050
20	$0.050
21	$0.050
22	$0.050
23	$0.050
24	$0.050
25	$0.060
26	$0.060
27	$0.060
28	$0.060
29	$0.060
30	$0.080
31	$0.080
32	$0.080
33	$0.080
34	$0.080
35	$0.090
36	$0.090
37	$0.090
38	$0.090
39	$0.090
40	$0.100
41	$0.108
42	$0.118
43	$0.128

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

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

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

Rates (cost per $1,000 of coverage per month) are based on the Insured'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	÷	$1,000	=	50	x	$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
15	$0.162
16	$0.190
17	$0.208
18	$0.224
19	$0.232
20	$0.234
21	$0.256
22	$0.242
23	$0.202
24	$0.184
25	$0.170
26	$0.170
27	$0.154
28	$0.150
29	$0.146
30	$0.142
31	$0.138
32	$0.150
33	$0.148
34	$0.160
35	$0.176
36	$0.188
37	$0.216
38	$0.244
39	$0.274
40	$0.308
41	$0.350
42	$0.396
43	$0.440
44	$0.484
45	$0.538
46	$0.600
47	$0.670
48	$0.742
49	$0.818
50	$0.906
51	$1.006
52	$1.116
53	$1.216
54	$1.312
55	$1.442
56	$1.584
57	$1.752
58	$1.932
59	$2.134
60	$2.372
61	$2.634
62	$2.932
63	$3.192
64	$3.500
65	$3.846
66	$4.216
67	$4.538
68	$4.850
69	$5.212
70	$5.638
71	$6.142
72	$6.740
73	$7.340
74	$8.012
75	$8.742
76	$9.634
77	$10.576
78	$11.416
79	$12.356
80	$13.564
81	$14.806
82	$16.234
83	$17.844
84	$19.202
85	$20.573
86	$22.137
87	$23.932
88	$25.745
89	$27.876
90	$30.427
91	$31.876
92	$34.257
93	$37.304
94	$39.972
95	$42.821
96	$45.858
97	$49.095
98	$52.551
99	$55.858

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.) 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 eoi@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.

MetLife
Metropolitan Life Insurance Company, New York, NY

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION

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

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 ☐ Self	☐ Male ☐ Female
Street Address	**City**	**State**	**Zip Code**
Date of Birth (MM/DD/YYYY)	**Daytime Phone #**	**Home Phone #**	**Email Address**

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 _____	☐	☐
3.	Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
	If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____		
4.	Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
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?	☐	☐
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) _____	☐	☐
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? Indicate reason _____	☐	☐
8.	Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9.	Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days? 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), 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 _____	☐	☐
	b. stroke or circulatory disorder? Indicate type _____	☐	☐
	c. high blood pressure?	☐	☐
	d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
	e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
	f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
	g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
	h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
	i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
	j. memory loss? Indicate type _____	☐	☐
	k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
	l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
	m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
	n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
	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? ☐ Yes ☐ 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): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. 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. ☐ 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: (____) ____-____

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: ( ) -

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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 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 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.

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.

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 of 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
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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)

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 Heath 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 (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

MetLife

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. 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

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. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

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 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.

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. 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
MetLife Insurance Company USA
SafeGuard Health Plans, Inc.
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife
Metropolitan Life Insurance Company, New York, NY

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

Upon receipt of the 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. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.