Southwestern Community College District Program Plan Benefit

All Active Full Time Employees and Members of the Board

Explore the coverage that makes it easy to give yourself and your loved ones more security today…and in the future.

Supplemental Term Life Insurance Coverage Options

For You	Multiples of $10,000. The maximum amount will be lesser of (1) or (2): (1) 5 times your annual earnings, rounded to the next higher multiple of $10,000 (2) $500,000. Non-Medical Limit: $100,000
For Your Spouse/Domestic Partner	Any multiple of $10,000, not to exceed $500,000 Non-Medical Limit: $25,000
For Your Dependent Children*	Option 1 - $2,000 Option 2 - $5,000 Option 3 - $10,000

*Child(ren)'s Eligibility: Dependent children ages from live birth to 26 years old are eligible for coverage.

Once Enrolled, You have Access to MetLife Advantages^{SM} - Services to Help Navigate What Life May Bring

Travel Assistance

A travel assistance benefit

Travel assistance services offers you and your family access to emergency services while you travel, plus the advantage of concierge assistance for personal and work-related travel and entertainment requests. This service provides you and your dependents with medical, legal, transportation and financial assistance 24 hours a day, 365 days a year when you are more than 100 miles away from home. You also have access to Mobile Assist Service to provide you information to help avoid expensive mobile telephone charges and help effectively use overseas options. Mobile Assist Service also offers a detailed guide that includes essential applications and resources and connects employees to their concierge services. Identity Theft Solutions is also available to help educate you on identity theft prevention and provide assistance in the event you are a victim of identity theft. Please visit the AXA website for more information.

http://webcorp.axa-assistance.com
Login: axa
Password: travelassist

Will Preparation [1]

To help ensure your decisions are carried out

When you enroll for supplemental term life coverage, you will automatically receive access to Will Preparation Services at no extra cost to you. Both you and your spouse/domestic partner will have unlimited in-person or telephone access to one of Hyatt Legal Plans' nationwide network of 14,000+ participating attorneys for preparation of or updating a will, living will or power of attorney.* When you use a participating plan attorney, there will be no charge for the services.* Like life insurance, a carefully prepared will (simple or complex), living will and power of attorney are important.

- A will lets you define your most important decisions, such as who will care for your children or inherit your property.
- A living will ensures your wishes are carried out and protects your loved ones from having to make very difficult and personal medical decisions by themselves. Also called an "advanced directive," it is a document authorized by statutes in all states that allows you to provide written instructions regarding use of extraordinary life-support measures and to appoint someone as your proxy or representative to make decisions on maintaining extraordinary life-support if you should become incapacitated and unable to communicate your wishes.
- Powers of attorney allow you to plan ahead by designating someone you know and trust to act on your behalf in the event of unexpected occurrences or if you become incapacitated

Call 1-800-821-6400 and a Client Service Representative will assist you.

* You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

Range of solutions for continuing workplace coverage

Additional Features

This insurance offering from your employer and MetLife comes with additional features that can provide assistance to you and your family.

Accelerated Benefits Option [2]

For access to funds during a difficult time

If you become terminally ill and are diagnosed with 12 months or less to live, you have the option to receive up to 90% of your life insurance proceeds. This can go a long way towards helping your family meet medical and other expenses at a difficult time. Amounts not accelerated will continue under your employer's plan for as long as you remain eligible per the certificate requirements and the group policy remains in effect. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code (26 U.S.C.Sec 101(g)).[1]

Accelerated Benefits Option is not the same as long term care insurance (LTC). LTC provides nursing home care, home-health care, personal or adult day care for individuals above age 65 or with chronic or disabling conditions that require constant supervision.

Conversion

For protection after your coverage terminates

You can generally convert your group term life insurance benefits to an individual whole life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or change in employee class. Conversion is available on all group life insurance coverages. Please note that conversion is **not** available on AD&D coverage. If you experience an event that makes you eligible to convert your coverage, please call 1-877-275-6387 to begin the conversion process. Please contact your plan administrator/employer for more information.

EXTENSION OF LIFE INSURANCE WHILE YOU ARE TOTALLY DISABLED

Offering continued coverage when you need it most

If You become Totally Disabled while You are insured for Supplemental or Dependent Life Insurance under this policy, You may qualify to extend certain insurance under this section. If extended, premium payment will not be required. We will determine if You qualify for this extension after We receive Proof that You have satisfied the conditions of this section.

What's Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance does not provide payment of benefits for death caused by suicide within the first two years (one year for group policies issued in Missouri, North Dakota and Colorado) of the effective date of the certificate or an increase in coverage. This exclusionary period is one year for residents of Missouri and North Dakota. If the group policy was issued in Massachusetts, the suicide exclusion does not apply to dependent life coverage. The suicide exclusion does not apply to residents of Washington, or to individuals covered under a group policy issued in Washington.

Additional Coverage Information

How To Apply*

Complete your enrollment form and return it to your Human Resources Manager. Be sure to indicate your Beneficiary.

Note: If you do not wish to make a change to your coverage, you do not need to do anything.

*All applications are subject to review and approval by Metropolitan Life Insurance Company. Based on the plan design and the amount of coverage requested, a Statement of Health may need to be submitted to complete your application.

For Employee Coverage

Enrollment in this Supplemental Term Life insurance plan is available without providing medical information as long as:

For Annual Enrollment

- The enrollment takes place prior to the enrollment deadline, and
- You are continuing the coverage you had in the last year

For New Hires

- The enrollment takes place within 31 days from the date you become eligible for benefits, and
- The enrollment takes place prior to the next annual enrollment period/the next Group Policy anniversary following the date you became eligible for benefits (note: this period will not be greater than 12 months, or less than 31 days), and
- You are enrolling for coverage that meets your needs by choosing multiples of $10,000

If you do not meet all of the conditions stated above, and if you enroll in amounts over the non-medical limit you will need to provide additional medical information by completing a Statement of Health form.

About Your Coverage Effective Date

If Actively at Work requirements are met, coverage will become effective on the first of the month following the receipt of your completed application for all requests that do not require additional medical information. A request for your amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of the date that notice is received that MetLife has approved the coverage or increase if you meet Actively at Work requirements on that date, or the date that Actively at Work requirements are met after MetLife has approved the coverage or increase.

Who Can Be A Designated Beneficiary?

You can select any beneficiary(ies) other than your employer for your Supplemental coverages, and you may change your beneficiary(ies) at any time. You can also designate more than one beneficiary. You are the beneficiary for your Dependent coverage.

[1] Will Preparation and MetLife Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio, a MetLife company. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and affiliates, Warwick, Rhode Island. For New York sitused cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

[2] The Accelerated Benefits Option is subject to state availability and regulation. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable federal tax treatment. If the accelerated benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation.

This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

This is a life insurance benefit that also gives you the option to accelerate some or all of the death benefit in the event you meet the criteria for a qualifying event described in the policy. This policy or certificate does not provide long-term care insurance subject to California long-term care insurance law. This policy or certificate is not a California Partnership for Long-Term Care program policy. This policy or certificate is not a Medicare supplement (policy or certificate)

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Southwestern Community College District are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Life coverages is/are provided under a group insurance policy (Policy Form GPNP99) issued to your employer by MetLife. Life coverages under your employer's plan terminates, when your employment ceases, when your Life contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

Keenan & Associates

MetLife

Southwestern Community College District

Voluntary Life Rates - Monthly Billing

	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate per $1,000	**$ 0.050**	**$ 0.050**	**$ 0.070**	**$ 0.090**	**$ 0.110**	**$ 0.200**	**$ 0.350**	**$ 0.590**	**$ 0.950**	**$ 1.340**	**$ 1.980**
$10,000	$0.50	$0.50	$0.70	$0.90	$1.10	$2.00	$3.50	$5.90	$9.50	$13.40	$19.80
$20,000	$1.00	$1.00	$1.40	$1.80	$2.20	$4.00	$7.00	$11.80	$19.00	$26.80	$39.60
$30,000	$1.50	$1.50	$2.10	$2.70	$3.30	$6.00	$10.50	$17.70	$28.50	$40.20	$59.40
$40,000	$2.00	$2.00	$2.80	$3.60	$4.40	$8.00	$14.00	$23.60	$38.00	$53.60	$79.20
$50,000	$2.50	$2.50	$3.50	$4.50	$5.50	$10.00	$17.50	$29.50	$47.50	$67.00	$99.00
$60,000	$3.00	$3.00	$4.20	$5.40	$6.60	$12.00	$21.00	$35.40	$57.00	$80.40	$118.80
$70,000	$3.50	$3.50	$4.90	$6.30	$7.70	$14.00	$24.50	$41.30	$66.50	$93.80	$138.60
$80,000	$4.00	$4.00	$5.60	$7.20	$8.80	$16.00	$28.00	$47.20	$76.00	$107.20	$158.40
$90,000	$4.50	$4.50	$6.30	$8.10	$9.90	$18.00	$31.50	$53.10	$85.50	$120.60	$178.20
$100,000	$5.00	$5.00	$7.00	$9.00	$11.00	$20.00	$35.00	$59.00	$95.00	$134.00	$198.00
$150,000	$7.50	$7.50	$10.50	$13.50	$16.50	$30.00	$52.50	$88.50	$142.50	$201.00	$297.00
$200,000	$10.00	$10.00	$14.00	$18.00	$22.00	$40.00	$70.00	$118.00	$190.00	$268.00	$396.00
$250,000	$12.50	$12.50	$17.50	$22.50	$27.50	$50.00	$87.50	$147.50	$237.50	$335.00	$495.00
$300,000	$15.00	$15.00	$21.00	$27.00	$33.00	$60.00	$105.00	$177.00	$285.00	$402.00	$594.00
$350,000	$17.50	$17.50	$24.50	$31.50	$38.50	$70.00	$122.50	$206.50	$332.50	$469.00	$693.00
$400,000	$20.00	$20.00	$28.00	$36.00	$44.00	$80.00	$140.00	$236.00	$380.00	$536.00	$792.00
$450,000	$22.50	$22.50	$31.50	$40.50	$49.50	$90.00	$157.50	$265.50	$427.50	$603.00	$891.00
$500,000	$25.00	$25.00	$35.00	$45.00	$55.00	$100.00	$175.00	$295.00	$475.00	$670.00	$990.00

Child Coverage Options	
$2,000	$0.17
$5,000	$0.42
$10,000	$0.83

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Division	Class	Dept Code
Southwestern Community College District	**Ts 05372883**			
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee in blue or black ink)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female	☐ Single ☐ Married
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	

☐ Employee ☐ Retiree	Job Title:	Basic Annual Earnings: $	☐ Salaried ☐ Hourly	Hours Worked Per Week:

☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand the amounts of insurance I request must comply with and are limited by the plan design described in my enrollment materials.

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

☐ Supplemental/Optional Life [1] (Buy up)
Enter amount requested $_____

☐ Supplemental/Optional Dependent Spouse [2] Life [1,3] (Buy up)
Enter amount requested $_____

☐ Supplemental/Optional Dependent Child Life [3] (Buy up)
Enter amount requested $_____

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

[2] Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

[3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to
MetLife Administration, P.O. Box 14593, Lexington, KY 40512-4593
Fax MetLife at 1-888-505-7446

FRAUD WARNINGS

Before signing this enrollment 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.

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 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.

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.

MetLife
Metropolitan Life Insurance Company, New York, NY

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.
☐ 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 (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	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 (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	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%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

Sign Here

Signature of Employee | Print Name | Date Signed (MM/DD/YYYY)

GEF09-1a

INSTRUCTIONS

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

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

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, the Employee's Spouse/Domestic Partner or the Employee's Child.) 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. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. 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. Emailed forms must be printed and signed before they are scanned and submitted.

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

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email:
eoi@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 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 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association		Group Customer #	Reporting Location #
Street Address	City	State	Zip Code

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year

Term Life Insurance

- ☐ Basic Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse/Domestic Partner Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____

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 ☐ Spouse/Domestic Partner ☐ Child	☐ Male ☐ 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*; and **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.

INSTRUCTIONS

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

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2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. 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. Emailed forms must be printed and signed before they are scanned and submitted.

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

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email:
eoi@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 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 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association		Group Customer #	Reporting Location #
Street Address	City	State	Zip Code

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year

Term Life Insurance

- ☐ Basic Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse/Domestic Partner Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____

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 ☐ Spouse/Domestic Partner ☐ Child	☐ Male ☐ 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*; and **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.

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 12t, 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. **For residents of all states except CT, please answer the following question**: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **For CT residents, please answer the following question: 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) or AIDS Related Complex (ARC)?	☐	☐
11. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure?	☐	☐
12. 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 (such as peripheral artery disease)? Indicate type _____	☐	☐
c. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
d. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
e. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
f. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
g. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
i. memory loss? Indicate type _____	☐	☐
j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
l. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
m. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
n. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
o. back, neck, knee, spinal, joint or other musculoskeletal disorder (such as herniated disc; back pain; cervical spondylosis; meniscal, cartilage or ligament tears or injuries; hip fracture; or tendonitis)? Indicate type _____	☐	☐
p. carpal tunnel syndrome?	☐	☐
q. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
r. thyroid or other gland disorder? Indicate type _____	☐	☐
s. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
t. 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 12t.

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

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 12t, 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. **For residents of all states except CT, please answer the following question**: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **For CT residents, please answer the following question: 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) or AIDS Related Complex (ARC)?	☐	☐
11. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure?	☐	☐
12. 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 (such as peripheral artery disease)? Indicate type _____	☐	☐
c. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
d. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
e. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
f. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
g. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
i. memory loss? Indicate type _____	☐	☐
j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
l. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
m. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
n. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
o. back, neck, knee, spinal, joint or other musculoskeletal disorder (such as herniated disc; back pain; cervical spondylosis; meniscal, cartilage or ligament tears or injuries; hip fracture; or tendonitis)? Indicate type _____	☐	☐
p. carpal tunnel syndrome?	☐	☐
q. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
r. thyroid or other gland disorder? Indicate type _____	☐	☐
s. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
t. 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 12t.

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

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 12t 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: (____) ____-____

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

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: (___) ___-_____

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

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 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.

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.

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

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.

Sign Here

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.

Sign Here

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

Relationship of Personal Representative

AUTHORIZATION

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

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

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

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

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

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