Metropolitan Life Insurance Company
Statement of Health Form Instructions

Based on your enrollment, a Statement of Health is required to complete your request for group insurance coverage. Below are instructions for Completing the Statement of Health Form.

A separate Statement of Health form is required for each Proposed Insured / Applicant requesting insurance.

PLEASE USE THE CHECKBOXES TO ENSURE PROPER COMPLETION OF THE FORM.

Information to be Completed by Employer

- ☐ Enter Employer Name
- ☐ Enter Customer Number
- ☐ Enter SOH Reporting Location (if applicable)
- ☐ Enter Employer Address
- ☐ Select type of Insurance
  - ☐ If Life Insurance, **enter the additional amount of insurance**
- ☐ Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

Information to be Completed by Proposed Insured / Applicant

The Proposed Insured / Applicant must complete all information located in the boxes at the top:

- ☐ Enter Employee Name and Social Security Number**
- ☐ Enter Relationship of Proposed Insured / Applicant to Employee
- ☐ Enter Proposed Insured / Applicant's
  - ☐ Name
  - ☐ Sex
  - ☐ Date of Birth
  - ☐ Mailing Address
  - ☐ Business Telephone Number
  - ☐ Home Telephone Number
  - ☐ Email Address
  - ☐ State of Birth
  - ☐ Country of Birth

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- ☐ Complete Question 1.
- ☐ Check "Yes" or "No" for Questions 2–6 (**all parts**).
- ☐ Complete Question 7.
- ☐ Complete the details section if ANY of the questions 2 through 6 were answered "Yes."

Signatures

- ☐ The Employee must always sign and date the **Statement of Health** form.
- ☐ The Proposed Insured / Applicant (if over the age of 18) must sign and date the **Statement of Health** and **Authorization** forms. If the Proposed Insured / Applicant is under the age of 18, his/her personal representative must sign and date the Authorization.

Upon completion, make a copy of the completed form for your records and FAX or MAIL the completed 3-pages to the Statement of Health (SOH) Unit at MetLife.

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

Note: Additional medical information may be required after initial review of completed forms. This information may be in the form of a physical examination, paramedical exam, or Attending Physician Report, in which correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned for completion. For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com.

MetLife®
Metropolitan Life Insurance Company, New York, NY

STATEMENT OF HEALTH FORM

To be Completed by the Employer **-PLEASE PRINT CLEARLY-**

Employer Name	Customer Number	Reporting Location Number	
Columbus State Community College	**147739**	**147739**	
Employer's Street Address	City	State	Zip Code
500 East Spring Street	**Columbus**	**OH**	**43215**

Insurance Requested (To be completed for each Proposed Insured / Applicant)

☐ Supplemental/Optional Life ☐ Dependent Life

Additional Amount of Life Insurance Subject to Medical Underwriting $_____

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete) First MI Last			**Employee Social Security Number (Must Complete)**	
Insurance is for ☐ Employee ☐ Spouse ☐ Child	Proposed Insured Name First MI Last		☐ Male ☐ Female	Date of Birth (Mo Day Yr)
Mailing Address	City		State	Zip Code
Business Phone Number ( )	Home Phone Number ( )	E-mail Address	State of Birth	Country of Birth

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Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

1. Height ____ feet ____ inches Weight ____ lbs

	Yes	No
2. Are you now:		
a. pregnant?	☐	☐
b. taking prescribed medications or on a prescribed diet? If "yes," list:_____	☐	☐
c. receiving or applying for any disability benefits including workers' compensation?	☐	☐
3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.)_____	☐	☐

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

	Yes	No		Yes	No
a. chest pain or heart trouble?	☐	☐	h. colitis, Crohn's or any intestinal disorder?	☐	☐
b. high blood pressure, stroke or circulatory disorder?	☐	☐	i. Epilepsy, paralysis or dizziness?	☐	☐
c. cancer or tumors?	☐	☐	j. mental or nervous disorder?	☐	☐
d. anemia, leukemia or other blood disorder?	☐	☐	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	☐	☐
e. diabetes?	☐	☐	l. arthritis, carpal tunnel, or any muscle		
insulin treated?	☐	☐	weakness?	☐	☐
f. asthma, tuberculosis, pneumonia, or other			m. kidney or urinary tract disorder?	☐	☐
lung disease?	☐	☐	n. thyroid or other gland disorder?	☐	☐
g. ulcers, stomach or liver disorder?	☐	☐	o. back, neck or spinal disorder?	☐	☐

	Yes	No
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐

7. Personal Physician:_____ Date and reason for last visit:_____
Address:_____ Phone Number:_____

Give full details for "Yes" answers on the next page.

Make A Copy For Your Records & FAX or MAIL Completed Forms to the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Fraud Warning:
If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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

All other states:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

Sign Here		Date Here	
	(Employee must always sign) Signed		Date Signed (Mo./Day/Yr.)
	(Proposed Insured if other than Employee and at least 18 years of age) Signed		Date Signed (Mo./Day/Yr.)

Make A Copy For Your Records & FAX or MAIL Completed Forms to
the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
  - 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; and
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, 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.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

_____

Signature of Proposed Insured or
Signature & Relationship of Personal Representative*

_____

Date Signed (Mo./Day/Yr.)

_____

Print Name of Proposed Insured

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