MetLife®
Metropolitan Life Insurance Company

Election of Portable Coverage Form for Group Term Life
and Accidental Death & Dismemberment (AD&D) Insurance Coverage

Important Information about MetLife's Portability Option

You're in a time of transition, and MetLife welcomes the opportunity to provide you and your dependents with an affordable option to continue the Group Life and AD&D Insurance coverage that you had with your former plan.

Some highlights of your Portability option...

- Continue the same or a lesser amount of Life or AD&D Insurance coverage that you had on yourself and your dependents at the time of your coverage termination through your former plan (See Part A of the Election Form).
- Continue the discontinued amount of Life or AD&D coverage that you had on yourself if your coverage is reduced due to age or a change to your plan which affects your amount of insurance for your class (See Part A of the Election Form).
- Apply for Preferred Life (lower) premium rates for you and your Spouse/Domestic Partner¤ by answering Medical Questions (See instructions below).
- Apply to increase your coverage amount for you and your Spouse/Domestic Partner/Domestic Partner *.
  - This may be done in $25,000 increments
  - Evidence of Insurability is required for Life Insurance
  - Evidence of Insurability is not required for AD&D Insurance. You may increase AD&D coverage without increasing your Life coverage.
- Full protection for you and your family. When you port coverage, you will have these valuable features: MetLife's Total Control Account® (TCA) for you and your dependent(s) and Accelerated Benefits Option (ABO) for you and your Dependent Spouse/Domestic Partner.

  * Portability is subject to state availability. The minimum amount an employee can continue on a portable basis is $10,000; the maximum is $2,000,000.

To Elect Portable coverage:

1. Complete the attached Election Form within 31 days from the date your benefits are terminated or reduced or 45 days from the date this notice is given, if notice is given more than 15 days but less than 91 days after the date benefits were terminated or reduced.
2. Select the portable coverage amount for you and your dependents (see attached Election Form Part B).
3. Designate your beneficiary(ies) and sign and date the form.

4a. To continue the same or a lesser amount of Life Insurance or any amount of AD&D insurance:
- Send your completed Election Form to:
  MetLife Recordkeeping Center, P.O. Box 14401, Lexington, KY 40512-4401.
- Upon receipt of your completed Election Form, MetLife will send your initial monthly bill directly to your home address.

4b. To increase your or your Spouse/Domestic Partner's amount of Life Insurance or to apply for Preferred Rates for you or your Spouse/Domestic Partner's Life Insurance:
- You must complete the attached Statement of Health Form.
- Send your completed Election Form and Statement of Health Form to:
  MetLife Recordkeeping Center, P.O. Box 14401, Lexington, KY 40512-4401.
  - ➢ Upon receipt of your completed Election Form and Statement of Health Form MetLife will determine if the evidence satisfies us.
  - ➢ We will initially bill you at the Preferred Life (lower) premium rates.
    - ❖ If the evidence satisfies us, MetLife will notify you that the lower premium rates will continue to apply. If you elected to increase the amount of your or your Spouse/Domestic Partner's Life Insurance, the MetLife notification will also contain the effective date of the increase amount.
    - ❖ If the evidence does not satisfy us, MetLife will notify you that the lower premium rates will no longer apply and the Non-Preferred (higher) premium rates will take effect. If you elected to increase the amount of your or your Spouse/Domestic Partner's Life Insurance, the MetLife notification will also confirm that your current amount of Life Insurance will remain inforce.

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

MetLife®

Metropolitan Life Insurance Company, New York, NY

ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is either the Employer, a Third Party Administrator (TPA) or MetLife.)

1. Immediately upon the Insured's eligibility for Portability*, complete Part A below and make a copy of this form.
   *Refer to the "AT YOUR OPTION: PORTABILITY" section of the Group Life and AD&D Certificate.
2. If the Reason for the Insured's Portability Eligibility is death or divorce, complete all of the fields in Part A except for the "Insured's Basic Annual Earnings" and "Was the insured actively at work on the date of separation?" with the Spouse/Domestic Partner's information, not the Employee's information. Complete the fields for the "Insured's Basic Annual Earnings" and "Was the insured actively at work on the date of separation?" with the Employee's information. In the column for Amount of Insurance Terminated or Reduced, leave the Insured amounts blank and enter the Dependent Spouse/Domestic Partner/Domestic Partner and Dependent Child(ren) amounts as applicable.
3. Provide the Eligible Insured 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

Employer's Name:	Group Report No.:	Sub Division:	Branch:
Insured's Portability Eligibility Date:	Date of This Notice:		
Insured's Name: (Last, First, Initial)	Social Security Number:	Date of Birth:	Sex: (M/F)
Insured's Mailing Address: (Street, City, State, Zip)			
Insured's Basic Annual Earnings: $	Reason for Insured's Portability Eligibility:		

Has coverage been assigned? ☐ Yes ☐ No

If yes, please specify coverage assigned _____ and attach a copy of assignment form.

Was the insured actively at work on the date of separation? ☐ Yes ☐ No

Recordkeeper's Name: _____

Name of person at Recordkeeper completing Part A: _____ Telephone Number: _____

RECORDKEEPER'S VERIFICATION OF AMOUNT(S) ELIGIBLE FOR PORTABILITY**:

Amount of Insurance Terminated or Reduced

Insured:

- Basic Life $_____
- Basic AD&D $_____
- Supplemental/Optional Life $_____
- Supplemental/Optional AD&D $_____
- Voluntary AD&D $_____
  ☐ Insured Only ☐ Insured + Dependents

Dependent Spouse/Domestic Partner:

- Dependent Life $_____
- Dependent AD&D $_____
- Voluntary AD&D $_____

Dependent Child(ren):

- Dependent Life $_____
- Dependent AD&D $_____
- Voluntary AD&D $_____

** If the insured's application for portability is due to a reduction in coverage, enter only the reduced amount.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Recordkeeping Center. If you have any questions, please call 1-888-252-3607.

(Continued on Following Page)

Part B – TO BE COMPLETED BY THE INSURED

MetLife provides coverage under a Trusteed Group Insurance policy.

Insured's Email Address:	Insured's Home Telephone No.:

Are you applying for Preferred Rates for yourself? ☐ Yes ☐ No

Are you applying for Preferred Rates for your Spouse/Domestic Partner? ☐ Yes ☐ No

Are you requesting an increase in coverage for yourself? ☐ Yes ☐ No

Are you requesting an increase in coverage for your Spouse/Domestic Partner? ☐ Yes ☐ No

Note: A Statement of Health form must be completed for each person for whom you are requesting Preferred Rates or an increase in coverage.

Portable Insurance Amount(s) Requested (Please round coverage to the nearest thousand)

	Same Amount	Increased Amount[1]	Decreased Amount	No Coverage
Insured: [2, 3]				
• Basic Life	☐	$_____	$_____	☐
• Basic AD&D [4]	☐	$_____	$_____	☐
• Supplemental/Optional Life	☐	$_____	$_____	☐
• Supplemental/Optional AD&D [4]	☐	$_____	$_____	☐
• Voluntary AD&D [4] ☐ Insured Only ☐ Insured + Dependents	☐	$_____	$_____	☐
Dependent Spouse/Domestic Partner: [3, 5]				
• Dependent Life	☐	$_____	$_____	☐
• Dependent AD&D [4]	☐	$_____	$_____	☐
• Voluntary AD&D [4]	☐	$_____	$_____ [6]	☐
Dependent Child(ren): [3, 5]				
• Dependent Life	☐	$_____	$_____	☐
• Dependent AD&D [4]	☐	$_____	$_____	☐
• Voluntary AD&D [4]	☐	$_____	$_____ [6]	☐

1. Increases in coverage may not be available in all jurisdictions.
2. The minimum amount you can continue on a portable basis is $10,000; the maximum is $2,000,000.
3. In order to port a coverage for yourself or your dependents, you must have had that coverage under your former plan at the time of your coverage termination.
4. AD&D coverage is available without Life Insurance coverage.
5. Subject to state limits, the Dependent Spouse/Domestic Partner amount can be greater than the Insured Amount. For Insured and Spouse/Domestic Partner coverage: Spouse/Domestic Partner minimum is $2,500. For Spouse/Domestic Partner only coverage: Spouse/Domestic Partner minimum is $10,000. The Child minimum is $1,000.
6. Use these fields only when the Spouse/Domestic Partner and Child Voluntary AD&D amount is not related to the Insured's Voluntary AD&D amount.

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

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attach a separate sheet of paper, signed and dated)

	First Name	MI	Last Name	Sex (M/F)	Date of Birth (Mo./Day/Yr.)
Spouse/Domestic Partner:					
Child(ren):					

Please retain a copy of the fully-completed form for your records and return the original to MetLife Recordkeeping Center. If you have any questions, please call 1-888-252-3607.

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PART B - TO BE COMPLETED BY THE INSURED (Continued)

DESIGNATION OF BENEFICIARY FOR INSURED LIFE BENEFITS (Dependent Life Benefits are payable as specified in the Certificate)

☐ I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death. I understand I have the right to change this designation at any time.

☐ 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.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

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

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

Declaration and Signature — I declare that all information given above is true and complete to the best of my knowledge and belief.

Sign Here _____ Signature of Insured

Date Here _____ Date Signed (Mo./Day/Yr.)

Please retain a copy of the fully-completed form for your records and return the original to MetLife Recordkeeping Center. If you have any questions, please call 1-888-252-3607.

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

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

TABLE A
LIFE INSURANCE ONLY PREFERRED MONTHLY TERM RATES

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.050	$0.050
16	$0.050	$0.050
17	$0.050	$0.050
18	$0.050	$0.050
19	$0.050	$0.050
20	$0.050	$0.050
21	$0.050	$0.050
22	$0.050	$0.050
23	$0.050	$0.050
24	$0.050	$0.050
25	$0.060	$0.060
26	$0.060	$0.060
27	$0.060	$0.060
28	$0.060	$0.060
29	$0.060	$0.060
30	$0.080	$0.080
31	$0.080	$0.080
32	$0.080	$0.080
33	$0.080	$0.080
34	$0.080	$0.080
35	$0.090	$0.090
36	$0.090	$0.090
37	$0.090	$0.090
38	$0.090	$0.090
39	$0.090	$0.090
40	$0.100	$0.100
41	$0.108	$0.108
42	$0.118	$0.118
43	$0.128	$0.128
44	$0.138	$0.138
45	$0.150	$0.150
46	$0.163	$0.163
47	$0.178	$0.178
48	$0.194	$0.194
49	$0.211	$0.211
50	$0.230	$0.230
51	$0.261	$0.261
52	$0.295	$0.295
53	$0.335	$0.335
54	$0.379	$0.379
55	$0.430	$0.430
56	$0.468	$0.468
57	$0.510	$0.510
58	$0.556	$0.556
59	$0.606	$0.606
60	$0.660	$0.660
61	$0.752	$0.752
62	$0.858	$0.858
63	$0.977	$0.977
64	$1.114	$1.114
65	$1.270	$1.270
66	$1.399	$1.399
67	$1.541	$1.541
68	$1.698	$1.698
69	$1.870	$1.870
70	$2.060	N/A
71	$2.228	N/A
72	$2.409	N/A
73	$2.605	N/A
74	$2.818	N/A
75	$3.047	N/A
76	$3.295	N/A
77	$3.564	N/A
78	$3.854	N/A
79	$4.168	N/A
80	$4.460	N/A
81	$4.910	N/A
82	$5.410	N/A
83	$5.960	N/A
84	$6.560	N/A
85	$7.220	N/A
86	$7.950	N/A
87	$8.760	N/A
88	$9.650	N/A
89	$10.630	N/A
90	$11.710	N/A
91	$12.900	N/A
92	$14.190	N/A
93	$15.630	N/A
94	$17.210	N/A
95	$18.950	N/A
96	$20.870	N/A
97	$22.990	N/A
98	$25.320	N/A
99	$27.880	N/A

Example Calculation of Premium For Insured Only:

$50,000	÷	$1,000	=	50	x	$0.150	= $7.50 (Monthly Premium)
Amount of Coverage selected				# of units		Rate based on Age 45	

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

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

TABLE B
LIFE INSURANCE ONLY NON-PREFERRED MONTHLY TERM RATES

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

Example Calculation of Premium For Insured Only:

$50,000	÷	$1,000	=	50	x	$0.538	= $26.90 (Monthly Premium)
Amount of Coverage selected				# of units		Rate based on Age 45	

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

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

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

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.085	$0.075
16	$0.085	$0.075
17	$0.085	$0.075
18	$0.085	$0.075
19	$0.085	$0.075
20	$0.085	$0.075
21	$0.085	$0.075
22	$0.085	$0.075
23	$0.085	$0.075
24	$0.085	$0.075
25	$0.095	$0.085
26	$0.095	$0.085
27	$0.095	$0.085
28	$0.095	$0.085
29	$0.095	$0.085
30	$0.115	$0.105
31	$0.115	$0.105
32	$0.115	$0.105
33	$0.115	$0.105
34	$0.115	$0.105
35	$0.125	$0.115
36	$0.125	$0.115
37	$0.125	$0.115
38	$0.125	$0.115
39	$0.125	$0.115
40	$0.135	$0.125
41	$0.143	$0.133
42	$0.153	$0.143
43	$0.163	$0.153
44	$0.173	$0.163
45	$0.185	$0.175
46	$0.198	$0.188
47	$0.213	$0.203
48	$0.229	$0.219
49	$0.246	$0.236
50	$0.265	$0.255
51	$0.296	$0.286
52	$0.330	$0.320
53	$0.370	$0.360
54	$0.414	$0.404
55	$0.465	$0.455
56	$0.503	$0.493
57	$0.545	$0.535
58	$0.591	$0.581
59	$0.641	$0.631
60	$0.695	$0.685
61	$0.787	$0.777
62	$0.893	$0.883
63	$1.012	$1.002
64	$1.149	$1.139
65	$1.305	$1.295
66	$1.434	$1.424
67	$1.576	$1.566
68	$1.733	$1.723
69	$1.905	$1.895
70	$2.095	N/A
71	$2.263	N/A
72	$2.444	N/A
73	$2.640	N/A
74	$2.853	N/A
75	$3.082	N/A
76	$3.330	N/A
77	$3.599	N/A
78	$3.889	N/A
79	$4.203	N/A
80	$4.495	N/A
81	$4.945	N/A
82	$5.445	N/A
83	$5.995	N/A
84	$6.595	N/A
85	$7.255	N/A
86	$7.985	N/A
87	$8.795	N/A
88	$9.685	N/A
89	$10.665	N/A
90	$11.745	N/A
91	$12.935	N/A
92	$14.225	N/A
93	$15.665	N/A
94	$17.245	N/A
95	$18.985	N/A
96	$20.905	N/A
97	$23.025	N/A
98	$25.355	N/A
99	$27.915	N/A

Example Calculation of Premium For Insured Only:

$50,000	÷	$1,000	=	50	x	$0.185	= $9.25 (Monthly Premium)
Amount of Coverage selected				# of units		Rate based on Age 45	

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

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

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

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.197	$0.187
16	$0.225	$0.215
17	$0.243	$0.233
18	$0.259	$0.249
19	$0.267	$0.257
20	$0.269	$0.259
21	$0.291	$0.281
22	$0.277	$0.267
23	$0.237	$0.227
24	$0.219	$0.209
25	$0.205	$0.195
26	$0.205	$0.195
27	$0.189	$0.179
28	$0.185	$0.175
29	$0.181	$0.171
30	$0.177	$0.167
31	$0.173	$0.163
32	$0.185	$0.175
33	$0.183	$0.173
34	$0.195	$0.185
35	$0.211	$0.201
36	$0.223	$0.213
37	$0.251	$0.241
38	$0.279	$0.269
39	$0.309	$0.299
40	$0.343	$0.333
41	$0.385	$0.375
42	$0.431	$0.421
43	$0.475	$0.465
44	$0.519	$0.509
45	$0.573	$0.563
46	$0.635	$0.625
47	$0.705	$0.695
48	$0.777	$0.767
49	$0.853	$0.843
50	$0.941	$0.931
51	$1.041	$1.031
52	$1.151	$1.141
53	$1.251	$1.241
54	$1.347	$1.337
55	$1.477	$1.467
56	$1.619	$1.609
57	$1.787	$1.777
58	$1.967	$1.957
59	$2.169	$2.159
60	$2.407	$2.397
61	$2.669	$2.659
62	$2.967	$2.957
63	$3.227	$3.217
64	$3.535	$3.525
65	$3.881	$3.871
66	$4.251	$4.241
67	$4.573	$4.563
68	$4.885	$4.875
69	$5.247	$5.237
70	$5.673	N/A
71	$6.177	N/A
72	$6.775	N/A
73	$7.375	N/A
74	$8.047	N/A
75	$8.777	N/A
76	$9.669	N/A
77	$10.611	N/A
78	$11.451	N/A
79	$12.391	N/A
80	$13.599	N/A
81	$14.841	N/A
82	$16.269	N/A
83	$17.879	N/A
84	$19.237	N/A
85	$20.608	N/A
86	$22.172	N/A
87	$23.967	N/A
88	$25.780	N/A
89	$27.911	N/A
90	$30.462	N/A
91	$31.911	N/A
92	$34.292	N/A
93	$37.339	N/A
94	$40.007	N/A
95	$42.856	N/A
96	$45.893	N/A
97	$49.130	N/A
98	$52.586	N/A
99	$55.893	N/A

Example Calculation of Premium For Insured Only:

$50,000	÷	$1,000	=	50	x	$0.573	= $28.65 (Monthly Premium)
Amount of Coverage selected				# of units		Rate based on Age 45	

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

Please Note: The Dependent Child(ren) Rate is based on a flat monthly rate. Each child is covered for the same amount regardless of the number of children covered under the policy.

TABLE E
CHILD MONTHLY TERM RATES

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

TABLE F
AD&D INSURANCE ONLY MONTHLY TERM RATES

AD&D TERM RATES

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

VAD&D TERM RATES

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

INSTRUCTIONS

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

INSTRUCTIONS TO THE EMPLOYEE

A Statement of Health Form is required if you are:

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

1. Fill in the Insurance Information on the Statement of Health form.
   - Enter the amount subject to medical underwriting, if applicable. If only continuing the current amount of Life Insurance inforce, but applying for preferred rates, enter current amount of Life Insurance.
   - The Employee's Name and the Employee's Social Security Number must appear on the form.
   - Enter the Enrollment year or year of requested increase (usually current year) for reporting purposes only.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

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

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

1. The Employee should fill in the Insurance Information and give the form to you.
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 MAIL the original forms to:

▶ MetLife Recordkeeping Center
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.

STATEMENT OF HEALTH FORM

MetLife
Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by MetLife)

Name of Group Customer/Employer/Association	Group Customer #	Reporting Location #
MetLife Group Life and Health Insurance Program Trust	123470	

Street Address	City	State	Zip Code
1314 King Street	Wilmington	Delaware	19801

INSURANCE INFORMATION (To be Completed by the Employee)

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 $_____

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

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)	Relationship to Employee	☐ Male ☐ Female
	☐ Self ☐ Spouse/Domestic Partner	

Street Address	City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address

HEALTH INFORMATION

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

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

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

	Yes	No
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)? _____	☐	☐
4. Are you now, or have you in the past 5 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?	☐	☐
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.

	Yes	No
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:

		Yes	No
a.	cardiac or cardiovascular disorder?	☐	☐
b.	stroke or circulatory disorder?	☐	☐
c.	high blood pressure?	☐	☐
d.	cancer, Hodgkins 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?	☐	☐
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?	☐	☐
m.	multiple sclerosis, ALS or muscular dystrophy?	☐	☐
n.	lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o.	arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p.	back, neck, knee, spinal, joint or other musculosketal disorder?	☐	☐
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?	☐	☐
u.	sleep apnea	☐	☐

For "yes" answers, please provide full details on the next page in Section 2.

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

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes ______ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**
Treating Health Professional		

Personal Physician's Name: ______

Date of last visit: ______ Reason for visit: ______

Address ______

Street City State Zip Code

Telephone: ( ) -

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes ______ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**
Treating Health Professional		

Personal Physician's Name: ______

Date of last visit: ______ Reason for visit: ______

Address ______

Street City State Zip Code

Telephone: ( ) -

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes ______ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**
Treating Health Professional		

Personal Physician's Name: ______

Date of last visit: ______ Reason for visit: ______

Address ______

Street City State Zip Code

Telephone: ( ) -

SECTION 3

1. Personal Physician's Name: ______
   Date of last visit: ______ Reason for visit: ______
   Address ______
   Street City State Zip Code
   Telephone: ( ) -
2. Are you currently taking any other prescribed medications? ☐ Yes ☐ No
   Medication: ______ Condition/Diagnosis: ______
   Prescribing Physician's Name: ______
   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 insurance policy under which you are applying for coverage was issued.

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

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

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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

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

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

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

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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 my 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)

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DEC

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.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.

Sign Here

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