MetLife®
Metropolitan Life Insurance Company
200 Park Ave., New York, NY 10166

IDI Application & Forms

NEW YORK

Table of Contents

- Please print legibly in black ink.
- Forms required in all cases:
  - Part A & Part B of the application
  - Authorization – Must be signed and submitted with all cases
  - Consumer Privacy Notice – Must be left with the Client
  - Compensation Disclosure Statement - (ADG and MLR Only) Must be left with the client
- NY HIV Consent Form – Use this form whenever Blood and Urine are required.
- Please see the DI Reference Manual for specific information on all Underwriting Requirements.
- Please see the Application Submission Checklist (first page of the application) for additional guidelines.
- If Disability Buy-Sell is being purchased, please complete the Disability Buy-Sell Supplement, IDI2000-APP-DBO-NY.
- If Disability Business Overhead Expense is being purchased, please complete the Disability BOE Supplement, IDIAPP06-2-BOE.
- If RSDII is being purchased, please complete the RSDII Supplement, IDI2000-APP-RSP-NY.
- If Spousal Catastrophic Disability Benefit is being purchased, please complete the Spousal Catastrophic Supplement, IDIAPP07-1-NY.

MetLife®
Metropolitan Life Insurance Company
200 Park Ave., New York, NY 10166

Application for Individual Disability Income Insurance

NEW YORK

Submission Checklist

1. Is every question answered — legibly and completely in ink? ❒ **YES** ❒ **NO**
2. If the mode of payment chosen is IDI Bank Draft (Check-O-Matic), is a voided check attached? ❒ **YES** ❒ **NO**
3. Are all changes made initialed by the proposed insured? ❒ **YES** ❒ **NO**
4. If question 15 or 16 on page 6 is answered "Yes", complete an Aviation Questionnaire and/or Avocation Questionnaire. ❒ **YES** ❒ **NO**
5. Is the applicant aware that a phone interview may be required? ❒ **YES** ❒ **NO**
6. Paramedical examination, blood and urine tests completed on _____ OR scheduled on _____
7. Attending Physician's Statement (APS) ordered from
   _____on _____
   _____on _____
   _____on _____
8. Is proof of Income/financial documentation attached? ❒ **YES** ❒ **NO**
   IF NO, state why _____
   _____
9. If Life Insurance is being applied for with MetLife at this time, state which underwriting office: _____
   _____
10. Please attach page 3 of the IDI Illustration/Quote
11. Occupational Class Quoted (not binding) _____
    (6S, 6A, 5A, 5S, 5D, 5I, 4M, 4A, 3A, 2A, A, B)
12. Multi-Life Discount Quoted: ❒ 5% ❒ 10% ❒ 15% ❒ 20% ❒ _____%
13. Multi-Life Number _____
14. Is this a ❒ Small-Case Multilife or ❒ GSI Multilife case? ❒ **YES** ❒ **NO**
    IF YES, how many lives? _____ Approved Discount _____

Contact at Sales Office:

Name: _____ Phone: _____

Fax: _____ E-mail: _____

MetLife®
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Application for Individual Disability Income Insurance Part A.

PAGE 1

1. (a) Proposed Insured

Full Name First/Given Middle Last/Surname

Suffix (eg., Jr.) Prof. Desig. (Maiden name if applicable) Sex Date of Birth Age

(b) State of Birth _____
(Country, If other than U.S.)

(c) Are you a United States citizen? ❒ **YES** ❒ **NO**

IF NO, how long have you been a resident of the United States?

_____ Years _____ Months
Status of your visa (if applicable) ❒ Temporary ❒ Permanent

(d) Social Security Number _____

(e) Driver's License Number _____ State of Issue _____

(f) Do you read and write English? ❒ **YES** ❒ **NO**

IF NO, primary language you read and write _____

2. Residence:

Number Street

City State Zip

3. (a) Business Address:

Number Street

City State Zip

(b) Mail correspondence to: ❒ Home ❒ Business

(c) Employer's or Business Name: _____

(d) Type of Business:

_____

Business Owners Only

(e) What is your percentage of ownership?

_____

(f) How long have you been an owner?

_____

(g) How long has the business existed?

_____

(h) Number of employees in the business:

_____

(i) How is the business organized? ❒ Sole Proprietor ❒ Partnership ❒ C Corporation
❒ S Corporation ❒ PA ❒ PC ❒ LLC ❒ LLP

Application for Individual Disability Income Insurance

PAGE 2

4. (a) Primary Occupation:

_____

(b) Your exact duties and the percentage of time devoted to each duty including amount and type of travel, foreign and domestic:

_____ %

_____ %

_____ %

_____ %

(c) How many employees do you supervise?

_____

(d) How long have you been employed in your present occupation?

_____

(e) How long have you been employed by your present employer?

_____

If you answer No to question (f) or Yes to questions (g), (h) or (i), provide the information in the space allotted. If additional space is needed use the supplemental information section below and on page 10, if necessary.

(f) Are you actively at work at least 30 hours per week in the above occupation? ❒ **YES** ❒ **NO**

IF NO, give details. _____

_____

(g) Do you have any other full or part-time jobs? ❒ **YES** ❒ **NO**

IF YES, please give duties, hours worked and travel required.

_____

_____

(h) Do you plan to change jobs in the next six months? ❒ **YES** ❒ **NO**

IF YES, give details. _____

_____

(i) Are your aware of any fact that could change your occupational status or financial stability? ❒ **YES** ❒ **NO**

IF YES, give details. _____

_____

Supplemental Information Section

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Application for Individual Disability Income Insurance

PAGE 3

5. Base Disability Policy and Optional Benefits Applied For:

❒ Omni Advantage ❒ Omni Select ❒ Omni Essential

Monthly Benefit $_____ Premiums ❒ Level ❒ Step Rate
Maximum Benefit Period (years) ❒ 2 ❒ 5 ❒ To Age 65 (N/A for B) ❒ To Age 70*
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180 ❒ 365** ❒ 730**

❒ Additional Monthly Indemnity (AMI)

Monthly Benefit $_____
Maximum Benefit Period (years) ❒ 2 ❒ 5 ❒ To Age 65 (N/A for B) ❒ To Age 70*
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180 ❒ 365** ❒ 730**

Disability Income Optional Benefits

❒ Social Insurance Substitute Benefit Monthly Benefit $_____
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180 ❒ 365** ❒ 730**
❒ Guaranteed Insurability Option Amount* $_____
❒ Catastrophic Benefit Monthly Amount $_____
❒ Good Health Benefit/Refund of Premium
❒ Residual with Recovery Benefit* ❒ 24 mos. ❒ 36 mos.
❒ Residual without Recovery Benefit*
❒ Long-Term Care Guaranteed Purchase Option
❒ Cost Of Living Adjustment 3% Simple With Buy-Up
❒ Cost Of Living Adjustment 1-7% Compound With Buy-Up
❒ Lifetime (N/A in 3A,2A, A, B) ❒ Lifetime for AMI (N/A in 3A, 2A, A, B)
❒ Automatic Increase Benefit *
❒ Your Occupation (N/A in 4A, 3A, 2A, A, B) (N/A in Essential)
❒ Transitional Your Occupation (N/A Essential)
❒ 5 year (N/A in 3A, 2A, A, B) ❒ 10 year (N/A in 3A,2A, A, B)
❒ To Age 65 (N/A in 3A, 2A, A, B)
❒ Spousal Catastrophic
❒ Other_____

*** (N/A A,B)**

**** (365 & 730 - Not available with a 2yr B.P.)**

***** Class A 10-year Duration Only**

Complete the Spousal Catastrophic Supplemental Application

❒ **Priority Plus Disability Income Insurance***

Monthly Benefit $_____
Maximum Benefit Period (years) ❒ 2 ❒ 5 ❒ To Age 65 (N/A for B)
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180 ❒ 365** ❒ 730**
❒ Social Insurance Substitute (SIS) Monthly Amount $_____
❒ Residual
❒ Supplemental Monthly Benefit (SMB) Monthly Amount $_____
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180
❒ Additional Monthly Indemnity (AMI)
Monthly Benefit $_____
Benefit Period (years) ❒ 2 ❒ 5 ❒ To Age 65 (N/A for B) ❒ To Age 70*
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180 ❒ 365** ❒ 730**

Complete the BOE Supplemental Application

❒ **Business Overhead Expense Insurance**

❒ **Mortgage Comp Fixed Term Disability Income Insurance** (N/A for B)

Monthly Benefit $_____
Duration of Policy (years) ❒ 10*** ❒ 15 ❒ 20 ❒ 30
Note: Applicant's Age + Duration Must Not Exceed Age 65
Elimination Period (days) ❒ 60 ❒ 90 ❒ 180
Mortgage or Loan Date _____Mortgage or Loan Amount $_____
% of Mortgage for which you are responsible _____%
Name and Address of Mortgage or/Lending Institution:

_____

_____

Complete the Buy-Sell Supplemental Application

❒ **Buy-Sell Insurance**

Complete the RSDII Supplemental Application

❒ **Retirement Savings Disability Income Insurance (RSDII)**

Application for Individual Disability Income Insurance

PAGE 4

6. (a) Frequency of Premium Payment: ❒ Annual ❒ Semi-Annual ❒ Monthly

(b) Mode of Premium Payment: ❒ Direct (annual & semi-annual only) ❒ IDI Bank Draft (monthly only) ❒ Payroll Deduction (multilife only)

(c) Will the entire premium for this policy be paid directly by your employer? **❒ YES ❒ NO**

(d) IF YES, will any portion of this premium be treated as taxable income to you?

_____%

7. Amount paid with this Application/Supplement: $_____ or **❒ NONE**

Is this amount equal to at least one month's premium? **❒ YES ❒ NO**

No Conditional Receipt for the Disability Income Insurance policy can take effect unless one month's premium for that policy is received.

8. Revocable Beneficiary

Full Name | Relationship | Date of Birth

9. Do you have or have available to you through your employer, or are you applying for any other type of:

(a) Individual, Association or Group disability income insurance coverage? **❒ YES ❒ NO**

(b) Formal employer sick pay or Union disability income coverage not included in (a)? **❒ YES ❒ NO**

(c) Business Overhead Expense or Buy/Sell Disability coverage? **❒ YES ❒ NO**

IF YES, to question 9a, 9b or 9c, complete the following using the following codes for Questions 9 and 10 to indicate "Type": G-Group; A-Association; E-Employer Sick Pay or Union; B-Business Overhead Expense; B/S-Buy/Sell Disability Coverage

Disability Coverage In Force, Applied For or Available Through Your Employer

Company or Source	Type	Total Monthly Benefit	Social Insurance Offset	Issue Month/ Year	Elimination Period		Benefit Period	
					Accident	Sickness	Accident	Sickness

10. Is the coverage being applied for: replacing, increasing or decreasing any existing insurance with MetLife or any other insurance company? If yes, complete the following: **❒ YES ❒ NO**

Disability Coverage to be Replaced, Increased or Decreased

Insurance Company Name and Address	Policy Number	Monthly Benefit	Type	Issue Month/Year	Termination Month/Year	Premium Mode

Application for Individual Disability Income Insurance

11. Financial Information:

(Income as reported to IRS for Federal Income Tax Purposes)

	Current Year (Annualized)	Last Year	Two Years Ago
Employee/Salaried Earnings			
(a) Base Salary (W-2 Income)	$_____	$_____	$_____
(b) Commissions	$_____	$_____	$_____
(c) Bonus, Profit Sharing or Incentive Payments	$_____	$_____	$_____
Owner/Shareholder Earnings			
(d) Sole Proprietor net business earnings/losses	$_____	$_____	$_____
(e) Partnership/S-Corporation net business earnings/losses	$_____	$_____	$_____
(f) Net share of corporate earnings/losses	$_____	$_____	$_____
Total Earned Income (Sum of Lines a through f)	$_____	$_____	$_____
Other Income; Unearned Income			
(g) Dividends and Interest	$_____	$_____	$_____
(h) Net rental income before depreciation	$_____	$_____	$_____
(i) Other (identify source)_____	$_____	$_____	$_____

Current Net Worth

(j) Does your net worth exceed $5,000,000? ❒ **YES** ❒ **NO**

(If "Yes" give details below. Amounts expressed to the nearest $100,000 are acceptable)

	Assets
Cash, Savings, Stocks & Bonds	$_____
Personal Property (such as jewelry, furnishings)	$_____
Personal Residence	$_____
Other Real Estate	$_____
Business Interest(s)	$_____
Other (specify source) _____	$_____
Less: **Indebtedness**	$_____
Total	$_____

Application for Individual Disability Income Insurance

(k) Which tax forms are being submitted with this application?
❒ 1040s and all schedules ❒ W-2s ❒ Other _____

(l) In the past five years have you or any business in which you held at least a 5% interest filed for bankruptcy? ❒ **YES** ❒ **NO**

IF YES, give details, including date of discharge, status and type.

_____

_____

_____

12. (a) Have you: had a driver's license suspended or revoked in the last 3 years; been convicted of 3 or more moving violations; been convicted of driving while impaired or intoxicated? ❒ **YES** ❒ **NO**

IF YES, give details, including date of discharge, status and type.

(b) Other than above, have you been convicted of any felony or misdemeanor, or do you have any charges pending? ❒ **YES** ❒ **NO**

IF YES, give details.

_____

_____

_____

If you answered yes to any of these questions, please provide information in the space allotted. (Use Supplemental Information Section page 10, if necessary.)

13. Has any application for a policy of Life, Health or Disability Insurance on you ever been postponed, rated, modified, declined, rescinded or required an extra premium? ❒ **YES** ❒ **NO**

IF YES, give details.

_____

_____

_____

14. (a) Please provide the status of any licenses required by your profession:
In Effect:_____ Not In Effect:_____ Not Applicable:_____

(b) If you indicated that your license is "In Effect" in response to Question 14(a), has your license ever been: subject to any disciplinary action, revoked, suspended, or are there any charges currently pending against your license? ❒ **YES** ❒ **NO** ❒ **NOT APPLICABLE**

If you indicated that your license is "**Not in Effect**" in response to Question 14(a) or "**Yes**" to Question 14(b), please provide information in the space allotted below:

_____

_____

_____

15. Have you flown as a pilot, student pilot, or crew member in the last 2 years or do you intend to do so in the next 12 months? ❒ **YES** ❒ **NO**

IF YES, complete the Aviation Questionnaire.

16. Have you ever engaged in or do you plan to engage in: Automotive, Motorcycle (including off road use) or Power Boat Racing; Bobsledding; Snowboarding; Skiing; Underwater Cave Exploration; Water Skiing; White Water Rafting; Spelunking; Ballooning; Scuba Diving; Sky Diving; Bungee Jumping; Hang Gliding (including Slope Soaring, Parakiting, Ultralighting, etc.); Mountain Climbing; Parachuting; Snowmobile Racing; Slalom Racing; Rodeo Activities; Karate or Martial Arts? ❒ **YES** ❒ **NO**

IF YES, complete the Avocation Questionnaire.

Application for Individual Disability Income Insurance Part B

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Statements By the Proposed Insured

1. (a) Height _____ **(b)** Weight _____

2. How much time have you lost from work during the past 5 years because of accident or sickness? _____ Give details below. ❒ None

3. Date you last used tobacco in any form: Date _____ Type _____
❒ Never used tobacco

4. (a) Please provide the name, address and phone number of your personal/primary care physician(s) as well as the date and reason for your last consultation.
If none, check here ❒

Name, Address and Phone Number	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

(b) In addition, in the past 5 years, has any Acupuncturist, Chiropractor, Counselor, Health Facility, Practitioner, Psychiatrist, Psychologist, Social Worker, or Therapist examined or treated you? ❒ **YES** ❒ **NO**

Give details below for each instance:
(Use Supplemental Information Section, page 10 if more space is needed)

Name, Address and Phone Number of each Acupuncturist, Chiropractor, Counselor, Health Facility, Physician, Practitioner, Psychiatrist, Psychologist, Social Worker or Therapist	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

Application for Individual Disability Income Insurance

If you answered yes to any of these questions, please provide information in the space allotted. (Use Supplemental Information Section page 10, if necessary.)

5. Have you EVER received treatment, attention or advice for; or been diagnosed as having:

(a)	Any disease or disorder of the heart; arteries or veins; chest pains; high (hypertension) or low (hypotension) blood pressure?	❒ YES	❒ NO
(b)	Arthritis; any disease, disorder or deformity of the bones, muscles, tendons, or joints, including the spine; any neck or back problems or disorders; carpal tunnel syndrome; any auto immune diseases such as Lupus or Scleroderma?	❒ YES	❒ NO
(c)	Any mental, nervous or emotional problem, condition or disorder, including anxiety, depression or stress?	❒ YES	❒ NO
(d)	Stroke, embolism, thrombosis?	❒ YES	❒ NO
(e)	Cancer, tumor or polyp?	❒ YES	❒ NO
(f)	Diabetes, high blood sugar or low blood sugar (Hypoglycemia)?	❒ YES	❒ NO
(g)	Any disease or disorder of the lungs or respiratory system, asthma, allergy, emphysema, or Chronic Obstructive Pulmonary Disease?	❒ YES	❒ NO
(h)	Any disease or disorder of the liver, gall bladder, pancreas, digestive tract, including intestines; ulcer, colitis, hemorrhoids, or hernia?	❒ YES	❒ NO
(i)	Memory loss, loss of concentration, fatigue, neurologic disorder, unconsciousness, loss of cognition, dizziness, paralysis or numbness, impairment of nervous system, epilepsy, seizures, migraine headaches or post polio syndrome?	❒ YES	❒ NO
(j)	Any disease or disorder of the urinary tract or kidney; sugar, albumin or blood in urine?	❒ YES	❒ NO
(k)	Any physical deformity or physical impairment?	❒ YES	❒ NO
(l)	Any disease or disorder of the skin?	❒ YES	❒ NO
(m)	Any disease or disorder of glands; anemia, leukemia, bleeding or clotting disorder or other blood disorders?	❒ YES	❒ NO
(n)	Any disease or disorder of the prostate or testes; uterus, ovaries or breasts; pre-term labor or infertility?	❒ YES	❒ NO
(o)	Any disease or disorder or impairment of the eyes, ears, mouth, nose or throat; any loss of vision or hearing?	❒ YES	❒ NO
(p)	Endocrine disorders or goiter or disease or disorder of the thyroid gland?	❒ YES	❒ NO
(q)	Any sexually transmitted disease?	❒ YES	❒ NO
(r)	Adult Attention Deficit Disorder, Adult Attention Hyperactivity Disorder, Alzheimer's Disease, Chronic Fatigue Syndrome, Epstein-Barr Virus, Fibromyalgia, Lyme Disease, Myalgia or Encephalitis?	❒ YES	❒ NO

6. Have you EVER:

(a)	Been advised to have any medical test or surgical operation that was not performed, or had any medical test or surgical operation performed, or gone to a hospital, doctor's office, clinic, dispensary or sanatorium for observation, examination or treatment; and this information has not been revealed by previous questions?	❒ YES	❒ NO
(b)	Been advised to modify or restrict eating, drinking, or living habits because of any health conditions?	❒ YES	❒ NO
(c)	Had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of 10 pounds or more, swollen glands, patches in the mouth, visual disturbance, recurring diarrhea, fever or infection?	❒ YES	❒ NO

Application for Individual Disability Income Insurance

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If you answered yes to any of these questions, please provide information in the space allotted. (Use Supplemental Information Section below and on page 10, if necessary.)

7. Have you EVER:
been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or other immune deficiency? ❒ **YES** ❒ **NO**

8. (a) Are you currently disabled, or do you expect to be disabled? ❒ **YES** ❒ **NO**

(b) Have you received or applied for disability, workers' compensation, or military disability benefits from any source in the past 5 years? ❒ **YES** ❒ **NO**

(c) Are you pregnant? ❒ **YES** ❒ **NO**
IF YES, expected delivery date?_____

(d) Within the last five years, have you taken any prescription medications, over the counter herbal medications, or been advised by a physician to take any medications, or are you now taking any prescription medications or over the counter herbal medications? ❒ **YES** ❒ **NO**
IF YES, give details.

_____

_____

9. Have you EVER:
used heroin, cocaine, marijuana, barbiturates or other drugs, except as prescribed by a physician or other practitioner; abused alcohol or drugs; or received treatment or advice regarding the use of alcohol or drugs from a physician, other practitioner, or organization which assists those who have an alcohol or drug problem? ❒ **YES** ❒ **NO**

10. For any "Yes" answer to Questions 5 through 9, give details: (Use Supplemental Information Section if more space is needed)

Item No.	Name, Address and Phone Number of each Acupuncturist, Chiropractor, Counselor, Health Facility, Physician, Practitioner, Psychiatrist, Psychologist, Social Worker or Therapist	Date	Reasons for Consultation: Nature, Severity and Frequency of Symptoms; Diagnosis, Treatment and Current Status of Condition

(Supplemental Information Section for Applicant)
Provide additional application information on this page. This information will be included in the Policy.

Application for Individual Disability Income Insurance

Supplemental Information Section for Applicant
Provide additional application information on this page. This information will be included in the Policy.

Application for Individual Disability Income Insurance

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Please refer to page 12 for state specific variations.

Agreement

I have read this application and any supplemental applications or amendments, and to the best of my knowledge and belief, I agree that: (a) All statements and answers are true and complete; and (b) All of the information is correctly recorded in the application; and (c) Such written statements may be relied on by MetLife in order to determine if I qualify for issue of a policy.

I understand that the application seeks full disclosure of the information sought; and that no one has the right to alter or exclude or to direct me to alter or exclude any information from the application.

I understand that paying my insurance premiums monthly may result in a higher yearly out-of-pocket cost than a less frequent premium mode.

I understand that this application, any paramedical application, and any supplemental applications or amendments will become a part of any policies issued as a result of this application.

I understand that MetLife will rely on the fact that coverage under any policies listed in Part A, Question 10 on page 4 will end on the Effective Date of Termination shown. If such coverage does not end at that time, any policy issued as a result of this application will be void from the beginning; all premiums will be returned; and no benefits will be payable. MetLife has the right to contact any listed insurer after the Effective Date of Termination to confirm that coverage has ended.

Submission of Application Without Payment of Premium and Conditional Premium Receipt

The policy will not be in effect and MetLife will not have liability until (a) a policy is delivered and is accepted by me; and (b) the full first premium due is paid. The policy will then be in effect as of its date of issue if at the time it is delivered:

(a) the condition of my health, the amount of my income, and the status of my employment or occupation are the same as given in the application; and

(b) I, the proposed insured, have not received any medical advice or treatment from a physician or other medical practitioner since the date of this application.

If there are any exceptions to **(a)** or **(b)**, the policy will not be in effect and I will give MetLife details in writing.

Submission of Application With Payment of Premium and Conditional Premium Receipt

If I submit (1) month's premium and receive a Conditional Premium Receipt at the time I sign and submit this Application, coverage under a policy and the Conditional Premium Receipt will not be in effect and MetLife will have no liability until either MetLife issues the policy as applied for by me, or MetLife issues the policy other than as applied for by me and which is accepted by me.

If I become disabled while the Conditional Premium Receipt is in effect, the Maximum Benefit Period for all disability benefits paid under a Disability Income Insurance Policy issued to me as a result of that disability is 24 months. If I become disabled during the same time period under the terms of a Business Overhead Expense Policy, there is a limitation as to the amount of expenses for which I will be reimbursed under the policy issued to me. If I become disabled during the same time period under the terms of a Disability Buy-Sell Insurance Policy, there is a limitation on the amount of the Buy-Out Benefit I will receive under the policy issued to me.

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.

Signature of Witness (Licensed Resident Agent)	Place	Mo. Day Yr.	Signature of Proposed Insured
X			X

Application for Individual Disability Income Insurance

Personal History Interview

As part of your application process, MetLife, or someone it designates, will telephone you to verify information in this application, including your occupation, medical history and income. This phone call will take between 15 and 20 minutes to complete. Please indicate below, the best way to reach you.

Home:			
		❒ AM ❒ PM	( )
Day of Week	Date	Time	Phone
Work:			
		❒ AM ❒ PM	( )
Day of Week	Date	Time	Phone
Other:			
		❒ AM ❒ PM	( )
Day of Week	Date	Time	Phone

IDI Bank Draft Authorization

Be sure to enclose a voided blank check for the account you wish to use and sign this authorization.

I authorize:

(1) MetLife to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and

(2) the financial institution on which my enclosed sample check (marked VOID) is drawn, to:
(a) accept the deductions initiated by MetLife; and
(b) give MetLife my most recent address upon MetLife's request.

Withdrawals will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the effective date of the policy and on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

_____ _____

Signature of Account Holder for Monthly Automatic Deductions **Date**

If your check is drawn on a credit union, indicate credit union phone number:

(_____) _____

MetLife®
Metropolitan Life Insurance Company
200 Park Ave., New York, NY 10166

Application for Individual Disability Income Insurance

*** Home office copy, do not detach**

RECEIPT AND CONDITIONAL PREMIUM RECEIPT for Disability Income Insurance

Received from: _____ $_____ on _____
Name of Proposed Insured (Please print) Disability Income Premium Date

$_____ on _____
Overhead Expense Premium Date

$_____ on _____
Buy-Sell Premium Date

$_____ on _____
Total Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS RECEIPT UNLESS METLIFE ISSUES A STANDARD POLICY OR ISSUES A NON-STANDARD POLICY, WHICH YOU ACCEPT. PLEASE NOTE THAT ANY DISABILITY THAT IS INCURRED DURING THE RECEIPT PERIOD IS SUBJECT TO THE LIMITATIONS SET FORTH IN THE COVERAGE, TERMS AND LIMITATIONS SECTION BELOW.

I. DEFINITIONS:

Coverage Date means the later of: (1) the date the application was signed by You; or (2) the date You complete a medical examination if such an examination is required by Us.

Disabled or Disability means a disability as defined in any policy issued to You.

Initial Application Requirements means: (1) a completed application in which You have answered "No" to Question 8(a) in Part B; (2) if required by Us, a completed medical examination and receipt by Us of any attending physician statement(s), medical records and any other medical documents that We may require; and (3) at least one (1) month's premium must be submitted to Us at the time the application is signed. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

MetLife, We, Our or Us means Metropolitan Life Insurance Company.

Receipt means Conditional Premium Receipt.

Receipt Period means the period starting on the Coverage Date and ending on the earliest of: (a) the date MetLife issues a Standard Policy; (b) the date a Non-Standard Policy is delivered and accepted by You; or (c) 90 days after the Coverage Date.

Standard Policy means a policy issued for the coverage You applied for with Us.

Non-Standard Policy means a policy issued for coverage other than as applied for by You.

You or Your means the proposed insured.

II. CONDITIONS OF COVERAGE:

1. If, after MetLife receives (a) the Initial Application Requirements; and (b) evidence of insurability acceptable to Us, We determine that as of the Coverage Date You are insurable based upon Our underwriting criteria, then coverage under this Receipt and the policy issued to You will take effect on the Coverage Date.

   DURING THE RECEIPT PERIOD YOU WILL HAVE LIMITED COVERAGE AS OF THE COVERAGE DATE AS PROVIDED FOR IN THIS RECEIPT, EVEN IF THE POLICY IS ISSUED TO YOU WITH A LATER EFFECTIVE DATE.

   Any changes in Your health after the Coverage Date will not affect Our underwriting decision.
2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy issued to You.

III. COVERAGE, TERMS AND LIMITATIONS:

This Receipt covers a disability that is incurred during the Receipt Period. If you become disabled under the terms of a Disability Income Insurance Policy, We will pay benefits. **Regardless of the Maximum Benefit Period set forth in the Disability Income Insurance Policy issued to You, the Maximum Benefit Period for all benefits paid as a result of a disability incurred during the Receipt Period is 24 months.**

*** Home office copy, do not detach**

If You become disabled under the terms of a Business Overhead Expense Policy during the Receipt Period, We will reimburse covered expenses resulting from that disability. **All expenses reimbursed as a result of a disability incurred while this Receipt is in effect are limited to the lesser of: (1) for a Standard Policy or a Non-Standard Policy accepted by You, the expenses to be paid for the maximum benefit period; or (2) $120,000.**

If You become disabled under the terms of a Disability Buy-Sell Insurance Policy during the Receipt Period, We will pay a Buy-Out Benefit. **The Buy-Out Benefit will be limited to the lesser of (1) for a Standard Policy or a Non-Standard Policy accepted by You, the Maximum Buy-Out Benefit; or (2) $120,000.**

Please note, however, that this Receipt and any policy referenced above which is issued to You or any claim made during the Receipt Period will be subject to certain proof requirements, exclusions, limitations and other provisions that may prevent an insured from receiving any benefits under this Receipt or any policy referenced above, including, but not limited to, provisions under which this Receipt or the policy issued to You can be voided by MetLife. **However, with respect to a disability incurred during the Receipt Period, the Effective Date will be deemed the Coverage Date for purposes of applying the Preexisting Conditions Exclusion in any policy issued to You.**

IV. NO COVERAGE UNDER THIS RECEIPT:

If We: (1) issue a Standard Policy or Non-Standard Policy which You decline to accept delivery of; or (2) do not issue a policy within 60 days from the date the application was signed by You, there will be no coverage under this Receipt and any premium paid will be returned to You.

V. LIMITATION ON AUTHORITY:

No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Receipt. No agent, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of Our requirements.

CAUTION: MetLife relies on Your answers to all question in Part B of the application in accepting payment and issuing this Receipt. This Receipt will be null and void and the premium paid will be returned if MetLife does not issue a policy within 60 days from the date the application was signed by you.

I have read this Receipt , and reviewed my answers to all questions in Part B of the application. I represent that the answers to all those questions are true and complete to the best of my knowledge and belief. I understand and agree that, if MetLife does not issue a policy within 60 days from the date the application was signed by me, the amount of premium tendered will be returned and this Receipt will be null and void. I understand and agree to all of the terms of this Receipt. I have received a copy of this Receipt.

X _____ X _____

Signature of Proposed Insured — Date

No agent or financial services representative is authorized to accept any payment with the application if Question 8(a) in Part B is answered "Yes" or left blank.

Receipt of $_____ is acknowledged from _____ in connection with the application for Disability Income/Business Overhead Expense/Buy-Sell insurance on this date _____.

By:_____ Metropolitan Life Insurance Company

Countersignature

Title: _____District/Branch: _____

ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

MetLife®
Metropolitan Life Insurance Company
200 Park Ave., New York, NY 10166

Application for Individual Disability Income Insurance

PAGE 15

*** Detach for applicant**

RECEIPT AND CONDITIONAL PREMIUM RECEIPT for Disability Income Insurance

Received from: _____ $_____ on _____
Name of Proposed Insured (Please print) Disability Income Premium Date

$_____ on _____
Overhead Expense Premium Date

$_____ on _____
Buy-Sell Premium Date

$_____ on _____
Total Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS RECEIPT UNLESS METLIFE ISSUES A STANDARD POLICY OR ISSUES A NON-STANDARD POLICY, WHICH YOU ACCEPT. PLEASE NOTE THAT ANY DISABILITY THAT IS INCURRED DURING THE RECEIPT PERIOD IS SUBJECT TO THE LIMITATIONS SET FORTH IN THE COVERAGE, TERMS AND LIMITATIONS SECTION BELOW.

I. DEFINITIONS:

Coverage Date means the later of: (1) the date the application was signed by You; or (2) the date You complete a medical examination if such an examination is required by Us.

Disabled or Disability means a disability as defined in any policy issued to You.

Initial Application Requirements means: (1) a completed application in which You have answered "No" to Question 8(a) in Part B; (2) if required by Us, a completed medical examination and receipt by Us of any attending physician statement(s), medical records and any other medical documents that We may require; and (3) at least one (1) month's premium must be submitted to Us at the time the application is signed. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

MetLife, We, Our or Us means Metropolitan Life Insurance Company.

Receipt means Conditional Premium Receipt.

Receipt Period means the period starting on the Coverage Date and ending on the earliest of: (a) the date MetLife issues a Standard Policy; (b) the date a Non-Standard Policy is delivered and accepted by You; or (c) 90 days after the Coverage Date.

Standard Policy means a policy issued for the coverage You applied for with Us.

Non-Standard Policy means a policy issued for coverage other than as applied for by You.

You or Your means the proposed insured.

II. CONDITIONS OF COVERAGE:

1. If, after MetLife receives (a) the Initial Application Requirements; and (b) evidence of insurability acceptable to Us, We determine that as of the Coverage Date You are insurable based upon Our underwriting criteria, then coverage under this Receipt and the policy issued to You will take effect on the Coverage Date.

   DURING THE RECEIPT PERIOD YOU WILL HAVE LIMITED COVERAGE AS OF THE COVERAGE DATE AS PROVIDED FOR IN THIS RECEIPT, EVEN IF THE POLICY IS ISSUED TO YOU WITH A LATER EFFECTIVE DATE.

   Any changes in Your health after the Coverage Date will not affect Our underwriting decision.
2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy issued to You.

III. COVERAGE, TERMS AND LIMITATIONS:

This Receipt covers a disability that is incurred during the Receipt Period. If you become disabled under the terms of a Disability Income Insurance Policy, We will pay benefits. **Regardless of the Maximum Benefit Period set forth in the Disability Income Insurance Policy issued to You, the Maximum Benefit Period for all benefits paid as a result of a disability incurred during the Receipt Period is 24 months.**

*** Detach for applicant**

If You become disabled under the terms of a Business Overhead Expense Policy during the Receipt Period, We will reimburse covered expenses resulting from that disability. **All expenses reimbursed as a result of a disability incurred while this Receipt is in effect are limited to the lesser of: (1) for a Standard Policy or a Non-Standard Policy accepted by You, the expenses to be paid for the maximum benefit period; or (2) $120,000.**

If You become disabled under the terms of a Disability Buy-Sell Insurance Policy during the Receipt Period, We will pay a Buy-Out Benefit. **The Buy-Out Benefit will be limited to the lesser of (1) for a Standard Policy or a Non-Standard Policy accepted by You, the Maximum Buy-Out Benefit; or (2) $120,000.**

Please note, however, that this Receipt and any policy referenced above which is issued to You or any claim made during the Receipt Period will be subject to certain proof requirements, exclusions, limitations and other provisions that may prevent an insured from receiving any benefits under this Receipt or any policy referenced above, including, but not limited to, provisions under which this Receipt or the policy issued to You can be voided by MetLife. **However, with respect to a disability incurred during the Receipt Period, the Effective Date will be deemed the Coverage Date for purposes of applying the Preexisting Conditions Exclusion in any policy issued to You.**

IV. NO COVERAGE UNDER THIS RECEIPT:

If We: (1) issue a Standard Policy or Non-Standard Policy which You decline to accept delivery of; or (2) do not issue a policy within 60 days from the date the application was signed by You, there will be no coverage under this Receipt and any premium paid will be returned to You.

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CAUTION: MetLife relies on Your answers to all question in Part B of the application in accepting payment and issuing this Receipt. This Receipt will be null and void and the premium paid will be returned if MetLife does not issue a policy within 60 days from the date the application was signed by you.

I have read this Receipt , and reviewed my answers to all questions in Part B of the application. I represent that the answers to all those questions are true and complete to the best of my knowledge and belief. I understand and agree that, if MetLife does not issue a policy within 60 days from the date the application was signed by me, the amount of premium tendered will be returned and this Receipt will be null and void. I understand and agree to all of the terms of this Receipt. I have received a copy of this Receipt.

X _____ X _____

Signature of Proposed Insured Date

No agent or financial services representative is authorized to accept any payment with the application if Question 8(a) in Part B is answered "Yes" or left blank.

Receipt of $_____ is acknowledged from _____ in connection with the application for Disability Income/Business Overhead Expense/Buy-Sell insurance on this date _____.

By:_____ Metropolitan Life Insurance Company

Countersignature

Title: _____District/Branch: _____

ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

Application for Individual Disability Income Insurance

Producer Report and Information

1. How did the sale originate?
❒ Efforts of Writing Representative ❒ Applicant's request

❒ Other _____

2. Modal Premium $ _____

Annualized Premium $ _____

Production Credits $ _____

3. Did you call a MetLife office to pre-screen this applicant's eligibility? ❒ **YES** ❒ **NO**

4. Was the application completed face to face? ❒ **YES** ❒ **NO**

Where? ❒ Residence ❒ Business ❒ Other _____

After how many interviews? _____

5. Relationship to Proposed Insured:
❒ Not related ❒ Not previously known

6. Have you given the Proposed Insured the detachable Privacy Notice? ❒ **YES** ❒ **NO**

7. (a) In states that require it, have you given the "Outline of Coverage" form and/or a "Guarantee Association Notice" to the applicant? ❒ **YES** ❒ **NO** ❒ **N/A**

(b) In states that require it, have you attached a signed acknowledgement of its delivery? ❒ **YES** ❒ **NO** ❒ **N/A**

8. Is this Replacement insurance? ❒ **YES** ❒ **NO**
IF YES, provide reason

IF YES, in states requiring it, have you given Form 11886AH (or the appropriate state variation) to the applicant and attached the signed copy to this Application? ❒ **YES** ❒ **NO**

9. Have you given the "HIV Consent" form to the applicant? ❒ **YES** ❒ **NO**

10. Have you given the "Compensation Disclosure statement" form to the applicant? ❒ **YES** ❒ **NO**

11. State any other MetLife products owned by the proposed insured.

12. Indicate below any other information regarding the Proposed Insured's health, working environment, or financial status not revealed on the application:

I personally saw the Proposed Insured when the application was written and each question was asked of the Proposed Insured and answered as recorded. All answers above and on the application are correct to the best of my knowledge and belief. I certify that any written disclosure statements were given to the applicant no later than the date this application was signed.

I further certify that, if a premium was paid and a Conditional Premium Receipt ("Receipt") was provided to the applicant, I reviewed the terms and limitations of the Receipt with the applicant.

Signature and Title _____ Date _____

Application for Individual Disability Income Insurance

Sales Manager's Report

1. This is a bonafide application and to the best of my knowledge the information provided is complete. ❒ YES ❒ NO
2. Was the Producer/Representative licensed to write Personal Health Insurance in the state of residence of the applicant on the date the application was signed? ❒ YES ❒ NO
3. Has your commission address changed within the last 6 months? ❒ YES ❒ NO

Signature and Title _____ Date _____

	Producer	Producer/Representative Name (Please Print)	Office ID# or Location (Please Print)	Producer/ Rep ID # (if applicable)	Social Security Number	Signature	Share %
1.							
	Phone #		E-mail Address				
	Address						
2.							
	Phone #		E-mail Address				
	Address						
3.							
	Phone #		E-mail Address				
	Address						
4.							
	Phone #		E-mail Address				
	Address						
5.							
	Phone #		E-mail Address				
	Address						

Application for Individual Disability Income Insurance

Distribution Affiliation (Not for MLFS or NEF)

❒ General Agent ❒ Crump Group/BISYS ❒ AXA ❒ M-Financial
❒ Direct Broker ❒ GEN AM/Travelers ❒ NFP ❒ Plus Group
❒ LPL/First Global ❒ Bank of America ❒ SML
❒ Edward Jones ❒ Smith Barney/Citi ❒ Other _____

General Agency Producer Information If GA Split indicate

1.	Name:	GA Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
2.	Name:	GA Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
3.	Name:	GA Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	

Contact Information

Name:	Phone #:
Fax #:	E-mail:
Address:	

Writing Producer / Payee Information ***(if different to details on page 18)***

1.	Name:	SSN/Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
2.	Name:	SSN/Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
3.	Name:	SSN/Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
4.	Name:	SSN/Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	
5.	Name:	SSN/Tax ID:	
	Address:	Phone #:	Share %
	City State Zip:	Fax #:	

EBS&S Sales Office Information TO BE COMPLETED BY THE EBS&S OFFICE

EBS&S Group/GNA/GRO Rep	ID	EBS&S IDI Rep Name	ID	EBS&S IDI Specialist	ID

MetLife®
Metropolitan Life Insurance Company
200 Park Ave., New York, NY 10166

Authorization

In connection with an application for insurance, for underwriting and claim purposes, I authorize:

- Any medical practitioner or facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; group policyholder, contract holder, or any benefit plan administrator to give Metropolitan Life Insurance Company (the "Company"), or any third party acting on behalf of the Company in this regard:
  - personal information and data about me;
  - medical information, records and data, about me, including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about me 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 me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
  - information, records and data about me relating to mental illness, other than psychotherapy notes.
- The Company to redisclose information, records, and data received pursuant to this Authorization about me as authorized by me in writing or as otherwise permitted by applicable law.
- The Company, or any third party acting on behalf of the Company in this regard, to request and obtain consumer, investigative consumer or motor vehicle reports about me.
- Any employer, business associate, financial institution, or government agency to give the Company, or any third party acting on behalf of the Company in this regard, any information or data that it may have about my occupation, avocations, driving record, finances, character, reputation and aviation activities.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that the Company 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 the Company on the insurance applied for or on existing insurance with the Company, 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 the Company, may no longer be covered by those laws or regulations.
- I may ask to be interviewed if an investigative consumer report is ordered.

  Please call me at (_____) _____, time _____ if such report is ordered.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- This authorization will end 24 months from the date on this form or sooner if prescribed by law.

  I may revoke it at any time by writing to the Company at _____ and advising the Company that I have revoked this Authorization. Revocation may result in rejection of the application or in denial of coverage or a claim for benefits. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

_____ _____
Signature of Proposed Insured Date

_____
Print Name of Proposed Insured

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

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've requested. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to help prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. We may also need more information. This may include information about finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies. Our affiliates currently include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Work and work history
- Driving record
- Hobbies and dangerous activities
- Finances

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect Information: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have.

How We Use and Disclose Information: We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena;
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company;
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for;
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service;
- Telling your health care provider about a medical problem that you have but may not be aware of;
- Giving your information to a peer review organization if you have health insurance with us; and
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you have with us.

Proposed Insured: _____

New York Informed Consent Form For Blood and Urine Testing For The AIDS Virus And Other Conditions

☐ **Metropolitan Life Insurance Company**
200 Park Avenue, New York, NY 10166

☐ **New England Life Insurance Company**
501 Boylston Street, Boston, MA 02116-3700

☐ **Metropolitan Tower Life Insurance Company**
200 Park Avenue, New York, NY 10166

☐ **First MetLife Investors Insurance Company**
200 Park Avenue, New York, NY 10166

☐ **Metropolitan Insurance and Annuity Company**
200Park Avenue, New York, NY 10166

☐ **Paragon Life Insurance Company**
190 Carondelet Plaza, St. Louis, MO 63105

The Company indicated above is referred to as "the Insurer".

I hereby authorize a medical professional to withdraw blood from me by needle and a licensed laboratory through medically accepted procedures to perform blood and/or urine tests in connection with application(s) for insurance coverage I have made to the Insurer named above. These may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders, the presence of medications, drugs, nicotine, or their metabolites and also the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). I understand that the results of these tests will be used to determine my insurability.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Positive HIV antibody test results mean that antibodies to the virus are present in the blood and/or urine and that the person has been exposed to the virus. If test results are positive, it does not necessarily mean that the person has AIDS. Such person is, however, at an increased risk of developing AIDS or ARC (AIDS-related conditions). The Company uses FDA approved tests to determine that an HIV result is positive.

Further information about HIV testing, AIDS and counseling services can be obtained by calling the toll free New York AIDS hotline telephone number: 1-800-541-AIDS. The information provided includes information regarding the meaning of test results and the availability and location of AIDS related counseling services.

The Insurer will treat test results as confidential. I understand that if the HIV test results are other than negative the Insurer may disclose a generic code which signifies only a non-specific abnormality of the blood, urine or saliva to the Medical Information Bureau. I understand that the Insurer may disclose information regarding these results to its insurance affiliates, reinsurers, contractors or employees who perform business services for it, or where otherwise permitted or required by law.

I understand that, in the event that the HIV test results are other than negative it is recommended that I consult my own physician or other health care provider who can inform me more fully about the implication of the test results and perform further independent testing.

I have designated below that physician (or other person) to whom I wish test results sent in the event an adverse underwriting decision is based on HIV test results:

_____

Name of Physician		
Address		
City	State	Zip Code

_____ If a physician or other person is not named above, please contact me.

I hereby permit that the results of these tests including, specifically, the results of tests for HIV antibodies or antigens may be reported to and used by the Company for underwriting purposes.

☞

_____ _____
Name of proposed Insured (Please Print) Signature of Proposed Insured or Parent/Guardian

_____ _____
Witness (Agent) Date

New York Informed Consent Form For Blood and Urine Testing For The AIDS Virus And Other Conditions

☐ **Metropolitan Life Insurance Company**
200 Park Avenue, New York, NY 10166

☐ **New England Life Insurance Company**
501 Boylston Street, Boston, MA 02116-3700

☐ **Metropolitan Tower Life Insurance Company**
200 Park Avenue, New York, NY 10166

☐ **First MetLife Investors Insurance Company**
200 Park Avenue, New York, NY 10166

The Company indicated above is referred to as "the Insurer".

I hereby authorize a medical professional to withdraw blood from me by needle and a licensed laboratory through medically accepted procedures to perform blood and/or urine tests in connection with application(s) for insurance coverage I have made to the Insurer named above. These may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders, the presence of medications, drugs, nicotine, or their metabolites and also the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV). I understand that the results of these tests will be used to determine my insurability.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Positive HIV antibody test results mean that antibodies to the virus are present in the blood and/or urine and that the person has been exposed to the virus. If test results are positive, it does not necessarily mean that the person has AIDS. Such person is, however, at an increased risk of developing AIDS or ARC (AIDS-related conditions). The Company uses FDA approved tests to determine that an HIV result is positive.

Further information about HIV testing, AIDS and counseling services can be obtained by calling the toll free New York AIDS hotline telephone number: 1-800-541-AIDS. The information provided includes information regarding the meaning of test results and the availability and location of AIDS related counseling services.

The Insurer will treat test results as confidential. I understand that if the HIV test results are other than negative the Insurer may disclose a generic code which signifies only a non-specific abnormality of the blood, urine or saliva to the Medical Information Bureau. I understand that the Insurer may disclose information regarding these results to its insurance affiliates, reinsurers, contractors or employees who perform business services for it, or where otherwise permitted or required by law.

I understand that, in the event that the HIV test results are other than negative it is recommended that I consult my own physician or other health care provider who can inform me more fully about the implication of the test results and perform further independent testing.

I have designated below that physician (or other person) to whom I wish test results sent in the event an adverse underwriting decision is based on HIV test results:

Name of Physician		
Address		
City	State	Zip Code

_____ If a physician or other person is not named above, please contact me.

I hereby permit that the results of these tests including, specifically, the results of tests for HIV antibodies or antigens may be reported to and used by the Company for underwriting purposes.

MetLife®

Case Number(s) if known _____
(For sales office use only)

Authorization to Release Health-Related Information to the Producer

Metropolitan Life Insurance Company
MetLife Insurance Company of Connecticut
First MetLife Investors Insurance Company
Metropolitan Tower Life Insurance Company
New England Life Insurance Company

I authorize the insurance companies named above (collectively "MetLife") to disclose information about me, including health-related information, to the insurance producer named below for the purpose of providing me with additional information regarding the underwriting decision(s) made in connection with any application(s) I submit to any of the insurance companies named above for Life Insurance, Disability Income Insurance or Long-Term Care Insurance.

Print Name of Producer

_____ _____ _____
First Middle Last

Print Business Address of Producer City State Zip

_____ _____ _____ _____

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include information contained in medical records such as test results, and data on my medical care, treatment or surgery and prescription medicines. Additional information that may be disclosed includes information regarding treatment for sexually transmitted diseases, mental illness, psychiatric or psychological disorders and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information regarding HIV test results, AIDS and HIV related conditions will not be disclosed under the terms of this Authorization.

In no event will information regarding your health history be disclosed if prohibited by applicable law.

I understand that:

- **I am not required to sign this Authorization as a condition of my application for insurance from MetLife.**
- **Signing, not signing or revoking this Authorization will not affect my treatment or my payment, enrollment, or eligibility for MetLife insurance.**

I further understand that:

- This Authorization will cover applications for the products indicated above submitted to any of the insurance companies named above during the next 12 months, beginning on the date this Authorization is signed.
- Information disclosed pursuant to this Authorization may no longer be subject to MetLife's privacy policy.
- Information that may have been subject to 42 CFR Part 2 or the privacy rules adopted and subsequently amended by the United States Department of Health and Human services pursuant to the Health Insurance Portability and Accountability Act of 1996 or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- This Authorization will be valid for 12 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to revoke this Authorization at any time and may do so by writing to: MetLife, P.O. Box 489, Warwick, RI 02887. I further understand, however, that any action taken by MetLife in reliance on this Authorization prior to receipt of my revocation by MetLife will remain valid.
- I have a right to receive a copy of this Authorization.

A copy of this Authorization will be as valid as the original.

Signatures

Print Name of Proposed Insured Date of Birth

_____ _____ _____ _____
First Middle Last

If Proposed Insured is under 18, the ❑ **Parent** or ❑ **Guardian** is to sign below for such child.

Signature of Proposed Insured Date Signed at City State

▶ _____ _____ _____ _____

As witness, I attest to having observed the party named above sign in my presence.

Witness to Signature

▶ _____