Medical Information - Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the person for whom insurance is requested.

Metropolitan Life Insurance Company, New York, NY
SBC Medical Underwriting, PO Box 14593, Lexington, KY 40512-4593

To be Completed by the Employer

Employer Name			Customer Number	Reporting Location Number	
Employer's Street Address			City	State	Zip Code
Employee Name First MI Last			Employee E-mail Address	Social Security Number	
Daytime Phone Number	Date of Full-Time Hire	Work Status: ☐Active ☐Retired ☐Disabled		Annual Salary: $	

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

Insurance is for: ☐ Employee ☐ Spouse ☐ Child	Applicant Name First MI Last	☐ Male ☐ Female	Date of Birth (mm/dd/yy)	
Street Address	City		State	Zip Code

Total Insurance Requested (To be completed for each Applicant)

☐Basic Life (or Core) $_____ ☐Optional Life (or Buy-Up) $_____ ☐Short Term Disability $

☐Dependent Life (or Buy-Up) $_____ ☐Long Term Disability $

GEF02-1
ADM

1. Your: Height ____ feet ____ inches Weight ____ lbs.
2. Are you now:
   a. pregnant? ☐Yes ☐No
   b. taking prescribed medications or on a prescribed diet? ☐Yes ☐No
      If "yes," list:____
   c. receiving or applying for any disability benefits including workers' compensation? ☐Yes ☐No
3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ☐Yes ☐No
4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) ___________________ ☐Yes ☐No
5. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? ☐Yes ☐No
6. Have you ever been diagnosed, treated, tested or given medical advice by a physician or other health care provider for:

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

Medical Information - Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the person for whom insurance is requested.

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

8. Have you ever had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of 10 pounds or more, swollen glands, patches in the mouth, visual disturbance, or recurring diarrhea, fever or infection? ☐Yes ☐No

9. Personal Physician:____________________ Date and reason for last visit:____________________

   Address:____________________ Phone Number:____________________

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

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

____________________ ____________________

Applicant Signature Date (Mo./Day/Yr.)

Medical Information Form Will Not Be Processed Without Accompanying Authorization Form.

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 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 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 SBC Administration, P.O. Box 14593, Lexington, KY 40512-4593 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

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

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

Fraud Warning:

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

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

AUTHORIZATION

Fraud Warning (continued):

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

<u>Kansas and Oregon:</u> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

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

<u>Oklahoma</u>: 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.

<u>Massachusetts</u>: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil

<u>Virginia:</u> Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

In any other case, read the following warning.

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

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

Print Name of Employee	Signature of Employee	Date (Mo./Day/Yr.)
Print Name of Employee's Spouse	Signature of Employee's Spouse	Date (Mo./Day/Yr.)
Print Name of Child # 1	Signature of Child # 1 or Signature & Relationship of Personal Representative*	Date (Mo./Day/Yr.)
Print Name of Child # 2	Signature of Child # 2 or Signature & Relationship of Personal Representative*	Date (Mo./Day/Yr.)

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Privacy Notice To Our Customers

MetLife®

THIS PRIVACY NOTICE IS GIVEN TO YOU ON BEHALF OF METROPOLITAN LIFE INSURANCE COMPANY

TO PLAN SPONSORS AND GROUP INSURANCE CERTIFICATEHOLDERS: THIS NOTICE EXPLAINS HOW WE TREAT INFORMATION WE RECEIVE ABOUT ANYONE WHO APPLIES FOR OR OBTAINS OUR PRODUCTS AND SERVICES UNDER EMPLOYEE BENEFIT PLANS THAT WE INSURE OR GROUP INSURANCE CONTRACTS THAT WE ISSUE . PLEASE NOTE THAT WE REFER TO THESE INDIVIDUALS IN THIS NOTICE BY USING THE TERM "YOU", AS IF THIS NOTICE WERE BEING ADDRESSED TO THESE INDIVIDUALS.

Why We Need to Know About You: We need to know about you so that we can provide you with the insurance and other products and services you've asked for. We may also need information from you and others to help us verify your identity in order to prevent money laundering and terrorism.

What we need to know about you includes your address, age and other basic information. But we may have to know more about you, including your finances, employment, health, hobbies or business you conduct with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you we get mostly from you. But we may also have to find out more about you from other sources in order to make sure that what we know about you is correct and complete. Those sources may include your adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports, and they may disclose what they know about you to others.

How We Protect What We Know About You: 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 take steps to make our computer data bases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a MetLife 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 run our business
- Process data for us
- Perform research for us
- Audit our business
- Help us comply with the law

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
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- 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
- 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

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. By law, we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you; however, we cannot do this if the state law that applies to you does not allow it. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, 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. Medical Information will generally be disclosed through the licensed physician you choose or as otherwise required by law. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) 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 when we give your information to anyone outside MetLife.

How 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 contact us at our website, www.metlife.com, or write to your MetLife insurance company, c/o MetLife Privacy Office, P.O. Box 2006, Aurora, Illinois 60507-2006.