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

IDI Application & Forms

NEW JERSEY

Table of Contents

1. IDIAPP06-1-NJ
2. Authorization
3. Electronic Payment (EP) Account Agreement
4. Consumer Privacy Notice
5. Notice & Consent for HIV-Related Testing
6. Generic Replacement Notice
7. Compensation Disclosure Statement

- 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
- HIV Consent Form – Use this form whenever Blood and Urine are required.
- Replacement Form – Use this form when replacing other insurance.
- 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.
- If Disability Business Overhead Expense is being purchased, please complete the Disability BOE Supplement, IDIAPP06-2-BOE.

MetLife®
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Application for Individual Disability Income Insurance

NEW JERSEY

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 _____
15. Is this application associated with a GSI offer? ❒ **YES** ❒ **NO**

Contact at Sales Office:

Name: _____ Phone: _____

Fax: _____ E-mail: _____

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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

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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
❒ Cost Of Living Adjustment 0-10%
❒ 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) ❒ 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**

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; been told that you had; or had any known indication of:

(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. During the past 10 years has a member of the medical profession diagnosed you 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; 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

PAGE 10

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 includes any false, or misleading information on an application for an insurance policy is subject to criminal and civil penalities.

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

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

Application for Individual Disability Income Insurance

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*** 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 questions 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 any of these answers are incorrect or incomplete, or 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. I understand and agree that if the answers to any of the questions in Part B of the application are not true and complete or 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 questions 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 any of these answers are incorrect or incomplete, or 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. I understand and agree that if the answers to any of the questions in Part B of the application are not true and complete or 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

PAGE 18

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 30 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 | Birth Date

_____
Print Name of Proposed Insured

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

MetLife®

Electronic Payment (EP) Account Agreement

Instructions: Use this form to establish or change an electronic payment account as a payment method for policies and contracts issued by the companies listed below. Once you have established an EP Account, other products can be included with this account so that payments can be withdrawn on the same date from the same bank account. Please complete this form in its entirety to avoid any delays in processing. If you need assistance completing this form, please call your representative, sales office, or the appropriate number listed under How to Submit this Form.

The Company indicated in this section is referred to as **"the Company."**

- ☐ Metropolitan Life Insurance Company
- ☐ New England Life Insurance Company
- ☐ General American Life Insurance Company
- ☐ MetLife Insurance Company of Connecticut
- ☐ First MetLife Investors Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ MetLife Investors Insurance Company
- ☐ Metropolitan Tower Life Insurance Company

SECTION I - Type of Request

☐ New Authorization (To make regular withdrawals)

☐ Change of Bank Account (Prior Authorization)

☐ Add policy/contract to existing Electronic Payment Account # _____

Note: Individual Disability Income contracts can not be added to existing electronic payment accounts containing any other MetLife products.

SECTION II - Bank Account Owner Information

Primary Owner of the Bank Account: ☐ Individual or ☐ Business Entity

First Name _____ Middle Name _____ Last Name _____

Social Security Number _____

Business Entity _____ Tax ID Number If Company Check _____

Street Address _____

City _____ State _____ Zip _____

Joint Owner of the Bank Account:

First Name _____ Middle Name _____ Last Name _____

Social Security Number _____

SECTION III - Policy/Contract Payment Information

Please complete the following chart using a separate column for each policy/contract.	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____
Recurring Payment Type: Please choose one or more of the following: Premium, Loan, Annuity, PUAR/PAIR, ALBO, ADCW, etc.				
Recurring Payment Amount: Amount to draft every month				
Relationship of Bank Account Owner to Insured or Contract Owner: Please choose one of the following: Self, Spouse/Domestic Partner, Parent, Child, Grandparent, Employer, Guardian, or Contract Owner. (This section is not required for Individual Disability Income Policies) * Please review Bank Draft Disclosure for additional information.				
Initial Premium Advance Payment Amount: *Please review Bank Draft Disclosure for additional information.				

Withdrawal Date is the day of the month we will withdraw from your bank account. If you do not specify a date, monthly withdrawals will occur on the same day of the month as the issue date.

Please specify **only one** option: ☐ Issue Date of Policy/Contract ☐ Withdrawal on the ____ of each month

SECTION IV - Bank Information

Account Type: ☐ Checking ☐ Savings

We **CANNOT** establish electronic payments without a preprinted voided check or a letter from the bank. Additionally, we **CANNOT** establish electronic payments from starter checks, cash management, brokerage, or mutual fund checks, nor from foreign banks (unless the check is being paid in U.S. Dollars through a U. S. correspondent bank. The U.S. correspondent bank name must be on the check.)

IMPORTANT REMINDER-

IN ORDER TO PROCESS YOUR REQUEST
PLEASE TAPE YOUR PREPRINTED VOIDED CHECK OR DEPOSIT SLIP HERE.

Alternatively you may submit a letter on bank letterhead that includes the routing and account numbers.

Banking Institution Routing Number _____ Account Number _____

SECTION V - ACH Withdrawal Authorization

I, the Account Holder, hereby authorize

1. The companies named above (MetLife) to initiate withdrawal entries to the deposit account designated above at the Bank named above, using the Automated Clearing House;
2. Monthly recurring withdrawals; and
3. Withdrawals made from time to time, as I authorize.

I understand that:

1. The origination of electronic withdrawals to my account must comply with the provisions of U.S. law;
2. MetLife requires notification of at least 2 business days (5 business days for MetLife of Connecticut policies) before a scheduled payment to either terminate the EP or to prevent a scheduled payment;
3. If payments are made for insurance premiums, paying my insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.

SECTION VI - Signatures

Signature Requirements

All Bank Account Owners must sign this form. Please sign as shown below:

A Partnership	The full name of the firm should be printed with the signature of all general partners (not limited partners).
A Sole Proprietorship	The full name of the business should be printed with the signature of the owner followed by the word "owner."
A Trust	Signatures, followed by the word "Trustee," of all required Trustees. Also submit a Trust Certification, which is available from your representative, sales office, or the appropriate number listed under How to Submit This Form.
A Corporation	The signatures and titles of two officers.
An Individual acting on Behalf of the Owner	The full name of the Owner's fiduciary or agent and the legal documentation of the authority to act (e.g., power of attorney, guardianship papers, etc.).

By signing this document, I accept the term of this EP agreement.

Signature of Owner of the Bank Account ▶ _____ Title (If you are acting in a representative capacity) _____

Print Name of Individual Signing - First _____ Middle _____ Last _____

Signed at City _____ State _____ Date _____

Signature of Joint Owner of the Bank Account ▶ _____ Title (If you are acting in a representative capacity) _____

Print Name of Individual Signing - First _____ Middle _____ Last _____

Signed at City _____ State _____ Date _____

Before mailing, please include the following items:

- Preprinted voided check, deposit slip, or a letter from the bank
- All required signatures
- Policy/Contract Number
- Relationships indicated are of the Bank Account Owner to the Insured or Contract Owner

For Sales Office Use Only

Sales Office/Agency Number/Representative ID _____ Date _____

Sales Representative Name - First _____ Middle _____ Last _____

How to Submit this Form

Return pages 1 through 3 of the completed form to the address or fax number listed below for the Company that issued the policy. If policies are issued by more than one Company, return the completed form to any Company that issued at least one of the policies.

Issuing Company	Contact Phone Number	Fax Number	Address
Metropolitan Life Insurance Company MetLife Investors USA Insurance Company First MetLife Investors Insurance Company Metropolitan Tower Life Insurance Company	1-800-638-5433	1-908-655-9581	P. O. Box 354, Warwick, RI 02887-0354
New England Life Insurance Company	1-800-638-5433	1-908-655-9582	P. O. Box 323, Warwick, RI 02887-0323
General American Life Insurance Company MetLife Investors Insurance Company	1-800-638-5433	1-908-655-9583	P. O. Box 355, Warwick, RI, 02887-0355
MetLife Insurance Company of Connecticut **(For Life Insurance Policies Only)**	1-800-638-5433	1-908-655-9584	P. O. Box 321, Warwick, RI 02887-0321
Metropolitan Life Insurance Company **(For Individual Disability Income Policies Only)**	1-800-929-1492	1-908-552-3960	P. O. Box 30591, Tampa, FL 33630-3591

MetLife®

Bank Draft Disclosure

SECTION I: Automatic Withdrawals

- Recurring withdrawals will not start unless the policy/contract is in force.
- All withdrawals authorized will appear on your bank statement as "MetLife" or "MET-PAC."
- If the payment withdrawal date selected falls on a weekend, a holiday, or, in a shorter month, if the date selected is 29-31, the account will be billed on the next business day.
- By authorizing automatic withdrawals, MetLife established a MetLife Electronic Payment Account ("EP Account") for you. The EP Account is a payment method available to pay for policies/contracts issued or sold by MetLife companies. Once you have an EP Account, other MetLife products can be included with this account so that payments can be withdrawn on the same date.

SECTION II: Multiple Payment Withdrawals

Multiple payments may be withdrawn when:

- More than one policy/contract payment is due or needed to bring your policy/contract up to date.
- You requested a life insurance policy be back-dated resulting in more than one payment due at time of issue.
- The withdrawal date selected is after the contract date for life insurance policies with flexible premiums.

Note: Guarantees may be affected if payments are missed or delayed.

SECTION III: Initial Premium Advance Payment for Life Insurance

This option will allow the advance payment to be withdrawn immediately at signing of an application or during the underwriting process for life insurance. This option is available if the policy/contract applied for will be paid by recurring monthly withdrawal. The initial withdrawal is subject to the terms of the Temporary Insurance Agreement and Receipt.

SECTION IV: Ending the Withdrawal

The EP Account shall remain in full force and effect until one of the following occurs:

- You notify MetLife of the termination of the EP Account. MetLife requires notification of at least 2 business days (5 business days for MetLife of Connecticut policies) before a scheduled payment to either terminate the EP or to prevent a scheduled payment.
- MetLife notifies you of the termination of the EP Account.
- The policy(ies)/contract(s) is/are no longer in effect.
- The bank account used for withdrawals is closed or is otherwise terminated.

SECTION V: General Information

If you change your bank or the bank account that you use for monthly deductions, you must stop your current agreement and complete a new form.

- If you are not able to submit the new EP Agreement form in advance of the previously authorized draft date, please be sure to leave sufficient funds in your original account to cover the deduction for that month.
- To obtain a new form refer to contact information below.

Paying insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.

Please be sure to have adequate funds in your bank account to cover the total monthly deduction on the Debit Authorization Form.

- If there are inadequate funds, your payment(s) into the policy(ies)/contract(s) may not be made, or may be made late. Either situation could result in a life insurance policy losing certain guarantees or lapsing.
- Please note that many banks charge their customer when there are inadequate funds for an electronic draft.

Based on the policy/contract, premiums can increase.

Should a policy/contract no longer be paid by electronic draft, premiums or payments will be payable at the most frequent mode of payment available for that policy/contract.

MetLife will not consider refund requests until ten business days after the withdrawal.

If your mailing address changes, or if you want to determine the status of your policy and any guarantees, please contact your representative or call us at 1-800-METLIFE (1-800-638-5433).

MetLife®

Privacy Notice

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- ☐ Metropolitan Life Insurance Company
- ☐ New England Life Insurance Company
- ☐ MetLife Investors Insurance Company
- ☐ General American Life Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ Metropolitan Tower Life Insurance Company

SECTION I - Introduction

ⓘ This notice is given to you on behalf of the Company.

Thank you for your application. Now we will review what you told us and may get further information if needed.

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.)

SECTION II - 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.

SECTION III - 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.

This will help us decide if you are eligible for insurance from us and what we should charge for it. For example, anyone who has used nicotine in any form within the last year will not be eligible for our lowest premium rate.

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

If we ask an agency for an "investigative" report about you - which means that they will ask others about you - we will ask them to contact you as well. 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., 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired) or by contacting MIB at www.mib.com.

SECTION IV - 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.

SECTION V - 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 run our business
- Process information for us
- Perform research for us
- Audit our business
- Help us comply with the law

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 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 policy.

We may use what we know about you in order to offer you our other products and services. We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our own products and services to you. In addition, we can tell you about our affiliates and the products they offer.

Unless you tell us not to share information after receiving an "opt out" notice (see **"How You Can Make an `Opt Out' Election"** below), we may disclose certain information to our affiliates so that they can offer their products and services directly to you. Even if you do not "opt out," we will not disclose your health information to another company to permit it to market its products to you. We will also not share your information with other unaffiliated companies who may want to market their products directly to you, unless it is in connection with a joint marketing arrangement (as described below). We will not sell or otherwise disclose your information to, for example, a catalog company. 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. In addition, if we have joint marketing agreements with other unaffiliated companies, we may give them information about you so that we can offer products to you jointly or so they can offer products and services endorsed or sponsored by us to you. But we will not share information for joint marketing if you tell us not to or if the law that applies to you does not allow it.

How You Can Make an "Opt Out" Election: You can tell us not to share your information to let our affiliates market their products directly to you, or not to disclose your information to a third party in connection with a joint marketing arrangement. An "opt-out" election form will be provided to you at the time the policy is issued.

SECTION VI - 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.

SECTION VII - 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 the company you applied to, c/o MetLife Privacy Office, P. O. Box 489, Warwick, Rhode Island 02887-9954.

Proposed Insured: _____

Notice and Consent For HIV-Related Testing

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

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

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

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

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

☐ **General American Life Insurance Company**
13045 Tesson Ferry Road, St. Louis, MO 63128

☐ **MetLife Investors Insurance Company**
13045 Tesson Ferry Road, St. Louis, MO 63128

☐ **MetLife Investors USA Insurance Company**
222 Delaware Ave, Suite 900 P.O. Box 25130 Wilmington, DE 19899

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

The HIV Virus And AIDS. To evaluate your insurability, it is requested that you provide a blood or other bodily fluid sample for testing for the presence of HIV antibodies or antigens, as well as for other tests such as cholesterol, diabetes and immune disorders. The antibody test will determine the presence of antibodies to the human immunodeficiency virus (HIV), the virus associated with Acquired Immunodeficiency Syndrome (AIDS), a life-threatening disorder of the immune system. The HIV antigen test directly identifies AIDS viral particles. These tests are not tests for AIDS; AIDS can only be diagnosed by medical evaluation. By signing and dating this form, you agree that testing may be performed and that underwriting decisions will be based on the test results. You may refuse to be tested; however, such refusal may be used by the insurer as a reason to deny coverage.

Counseling/Anonymous Testing. Many public health organizations have recommended that before submitting to an HIV test, a person seek counseling to better understand the implications of the test. You may wish to consider counseling, at your expense, prior to being tested or to consult with your physician or local health department. You may also wish to be anonymously tested.

See reverse side for counseling information. For your information, HIV is transmitted: by sexual contact with an infected person; from an infected mother to her newborn infant; or by exposure to infected blood (as in needle sharing during intravenous drug use). HIV is not spread through casual contact, such as eating with, touching or kissing a person infected with the virus. Persons at high risk of contracting AIDS include: males who have had sexual contact with another male; intravenous drug users; hemophiliacs; and sexual contacts of any of these persons. A person may remain free of symptoms for years after becoming infected. It is thought that persons have a 25-50% chance of developing AIDS within 10 years of becoming infected.

The Test: Purpose And Accuracy. The HIV antibody test is a medically accepted three-test series which is extremely accurate and reliable and is performed by a licensed laboratory. It is not error free. Possible errors include:

a. False positives: the test may give a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: the test may give a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least four to 12 weeks for a positive test result to develop after a person is infected.

Meaning Of Positive HIV Test Result. A positive HIV test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system including AIDS or AIDS-related conditions. Federal authorities consider persons who are HIV antibody/antigen-positive to be infected with the AIDS virus and capable of infecting others. If you test positive, you should seek a follow-up visit with your personal physician and/or a public health clinic or an AIDS information organization. You may want to consider further independent testing.

Side Effects. A positive HIV test result may cause you significant anxiety, and may also result in uninsurability for life, health, or disability insurance policies you may apply for now or in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Notice and Consent For HIV-Related Testing

PAGE 2

(continued)

Confidentiality. All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed: to the proposed insured (unless state law requires disclosure only to a physician; see Notification section); to the person legally authorized to consent to the test; to a licensed physician, medical practitioner, or other person designated by the proposed insured; if your HIV test is other than normal, to the Medical Information Bureau (MIB), a national insurance data bank, using a non-specific code, indicating only an abnormal test, to assure confidentiality; for statistical reports that do not disclose the identity of any particular proposed insured; to employees, reinsurers, or contractors of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer; and to Insurer's legal counsel who needs such information to represent the Insurer effectively in matters concerning the proposed insured. Results will not otherwise be disclosed except as allowed by law or as authorized by you. Results will not be disclosed to your agent or broker. You may request by notice to the Insurer the names of the specific individuals or organizations that: will have access to your file; will receive a copy of your results; or will keep the test information in a data bank or other file.

Notification. If your test results are negative, no routine notification will be sent to you unless you complete the following:

Name to whom to disclose negative test results: _____

Address: _____

If your HIV test results are other than normal, you or a person you designate may receive the results directly except in states that prohibit direct notification (see list below). In states that prohibit direct notification, if you do not name a physician, the Insurer must notify the health department who will then notify you. It is recommended that you designate a physician, health department, or local organization (see reverse side) to receive the test result because a trained person should deliver the information so that you can understand the meaning of the test result.

Physician, health department, or organization for reporting a positive test result: _____

Address: _____

Prevention. Persons who have a history of high-risk behavior should modify these behaviors to prevent getting or giving AIDS, regardless of whether or not they are tested. Specific important changes in behavior include safe sex practices (including latex condom use) and not sharing needles.

Consent. I have read and I understand this Notice and Consent for HIV-Related Testing.I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above in the Confidentiality and Notification sections.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent is valid for six months from the date signed unless revoked by me in writing. A revocation will not affect disclosures already made, but no further disclosure will be made thereafter without my express written consent.

_____ Name of Proposed Insured (Please Print)

_____ Signature of Proposed Insured or Parent/Guardian

_____ Witness

_____ Date

Notice and Consent For HIV-Related Testing

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

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

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Counseling/Anonymous Testing. Many public health organizations have recommended that before submitting to an HIV test, a person seek counseling to better understand the implications of the test. You may wish to consider counseling, at your expense, prior to being tested or to consult with your physician or local health department. You may also wish to be anonymously tested.

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Side Effects. A positive HIV test result may cause you significant anxiety, and may also result in uninsurability for life, health, or disability insurance policies you may apply for now or in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Notice and Consent For HIV-Related Testing

PAGE 2

(continued)

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Notification. If your test results are negative, no routine notification will be sent to you unless you complete the following:

Name to whom to disclose negative test results: _____

Address: _____

If your HIV test results are other than normal, you or a person you designate may receive the results directly except in states that prohibit direct notification (see list below). In states that prohibit direct notification, if you do not name a physician, the Insurer must notify the health department who will then notify you. It is recommended that you designate a physician, health department, or local organization (see reverse side) to receive the test result because a trained person should deliver the information so that you can understand the meaning of the test result.

Physician, health department, or organization for reporting a positive test result: _____

Address: _____

Prevention. Persons who have a history of high-risk behavior should modify these behaviors to prevent getting or giving AIDS, regardless of whether or not they are tested. Specific important changes in behavior include safe sex practices (including latex condom use) and not sharing needles.

Consent. I have read and I understand this Notice and Consent for HIV-Related Testing.I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above in the Confidentiality and Notification sections.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent is valid for six months from the date signed unless revoked by me in writing. A revocation will not affect disclosures already made, but no further disclosure will be made thereafter without my express written consent.

Notice and Consent For HIV-Related Testing

Counseling Information about HIV testing and AIDS can be obtained by contacting your private physician, a public clinic, your local county health department or an AIDS information organization in your city. Certain state hotline numbers are listed below.

In California:

The San Francisco AIDS Foundation at	415-864-5855
The AIDS Project Los Angeles at	213-380-2000
The San Diego AIDS Project at	619-548-0300
The AIDS Project - East Bay at	415-420-8181
AIDS Services Foundation of Orange County at	714-646-0411
ARIS Project at	408-370-3272
Central Valley Aids Team at	209-264-2436
Sacramento Aids Foundation at	916-448-2437

In the event the result is positive, you are urged to contact a private physician, County Health Department, State Department of Health Services, local medical society or alternative test site for appropriate counseling. Any result sent directly to you will be sent by registered mail with delivery restricted only to you.

In Hawaii:

HILO at 933-4678	Lanai at 565-6411
Kuna at 322-9705	Molokai at 553-3145
Maui at 243-5075	Kauai at 822-3830

In Montana:

If you prefer, anonymous testing is available. Information concerning locations of anonymous testing sites can be obtained from the Department of Health and Environmental Sciences of Montana, your local health department or by calling 1-800-233-6668.

In Nebraska:

Nebraska AIDS Project at 1-800-782-2437
AIDS Action Line at 1-800-235-2331

In Rhode Island:

Rhode Island Department of Health, Office of AIDS/STD at 401-222-2320
Rhode Island Project AIDS Hotline at 1-800-726-3010

In Virginia:

Virginia Health Department at 1-800-533-4148
Personal face-to-face counseling is available.

In Washington:

A list of counseling sites is available from the insurer. Contact the Underwriting Department or contact the Washington State Office of Prevention and Education Services HIV Antibody Testing/Counseling Services at 206-586-0426.

States that prohibit notifying the proposed insured directly of a positive HIV test result:

Alabama, Colorado, Delaware, Florida, Montana, and Washington

Notice to Applicant

PAGE 1

Regarding Replacement of Accident and Sickness Insurance

According to your application and the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Metropolitan Life Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____ _____

Applicant's Signature Date

Notice to Applicant

PAGE 2

Regarding Replacement of Accident and Sickness Insurance

According to your application and the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Metropolitan Life Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____ _____

Applicant's Signature Date

Compensation Disclosure Notice

MetLife

MetLife and its affiliated insurance companies and broker-dealers are committed to helping you select an appropriate product based on your financial needs and stated investment objectives.

Your MetLife sales representative ("Representative") is an employee of a MetLife Company, or associated with MetLife's New England Financial® distribution channel.

Your Representative is authorized to offer and sell products to you that are either issued or distributed by Metropolitan Life Insurance Company or certain of MetLife's affiliated insurance companies, or offered through one of MetLife's affiliated entities that is registered as a broker-dealer with whom you have an account relationship (each, a "MetLife Company" and, together, the "MetLife Companies").* Products from the MetLife Companies include fixed life insurance and annuities, property, casualty, and health insurance, variable annuities, and variable life insurance ("MetLife Products"). Your Representative also may be authorized to offer you certain products, including insurance, annuities, and mutual funds, issued by companies other than the MetLife Companies ("non-MetLife products").

Your Representative acts on behalf of the MetLife Companies in connection with the offer and sale of MetLife Products to you. He or she acts on behalf of a company other than MetLife in connection with the sale of non-MetLife products. Your Representative also may service your mutual funds, securities or insurance products on behalf of the company issuing the product.

Your Representative is compensated by a MetLife Company for sale, renewal and servicing of MetLife Products and certain authorized non-MetLife products. This compensation includes base commissions and other forms of compensation that may vary from product to product and by the amount of the purchase payment made by you. You should be aware that the amount of his or her compensation may increase in part based upon the relative amount of MetLife Products and certain non-MetLife products that he or she sells during a set period. He or she also is eligible for additional cash compensation (such as medical, retirement and other benefits) and non-cash compensation (such as conferences and sales support services) based on his or her sales of MetLife Products, certain authorized non-MetLife products, and overall sales and productivity. Your Representative may also receive compensation for the sale, renewal and servicing of authorized non-MetLife products directly from the issuing company. In some instances, MetLife Companies may also pay for expenses incurred by Representatives in connection with events for clients and prospects, training and education opportunities, and other miscellaneous expenses. MetLife receives compensation for non-MetLife Products sold by your Representative. This compensation will vary based upon an agreement between a MetLife Company and the issuing company and may include a bonus feature or a marketing allowance, which may be used in some instances to offset expenses associated with conducting due diligence on the company and its products, and hosting training and education, or recognition, conferences.

There are several aspects of management compensation, and one aspect is that your Representative's sales management is compensated for MetLife Products and approved non-MetLife Products that are sold by your Representative through MetLife. Generally, this compensation is aligned with that of your Representative, as noted above.

The services provided by your Representative may include:

- Discussing your current financial condition, goals and objectives;
- Gathering relevant financial information;
- Analyzing your financial situation (including among other things your needs, goals, risk tolerance, investment experience and time horizon) in order to determine appropriate strategies and recommendations of suitable investment or insurance products;
- Making recommendations regarding asset allocation;
- Making recommendations involving investment repositioning;
- Implementing these recommendations; and
- Reviewing your progress against your financial goals and objectives.

These services are **not** investment advisory or financial planning services subject to the Investment Advisors Act of 1940. If you are interested in such services, ask your Representative. Either your Representative or another MetLife or New England Financial Representative may be able to provide investment advisory or financial planning services. Before receiving those services, however, you will be provided with an additional disclosure and enter into a separate written agreement regarding those services as required by the Investment Advisors Act of 1940.

In addition to your Representative, certain independent brokers sell products through an association with a MetLife or New England Financial sales office. They are compensated by a MetLife Company for the sale, renewal and servicing of MetLife Products. Those brokers may receive increased compensation based upon the amount of MetLife Products sold during a set period.

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* The following are the MetLife Companies whose products your Representative may be authorized to sell: Metropolitan Life Insurance Company, Metropolitan Property and Casualty Insurance Company, Metropolitan Casualty Insurance Company, Metropolitan General Insurance Company, Metropolitan Direct Property and Casualty Insurance Company, Metropolitan Group Property and Casualty Insurance Company, Metropolitan Lloyds Insurance Company of Texas, Economy Fire & Casualty Company, Economy Preferred Insurance Company, Economy Premier Assurance Company, First MetLife Investors Insurance Company, MetLife Investors USA Insurance Company, MetLife Investors Insurance Company, MetLife Insurance Company of Connecticut, New England Life Insurance Company, General American Life Insurance Company, MetLife Securities, Inc., Walnut Street Securities, Inc., New England Securities Corporation and Tower Square Securities, Inc. For more information, please refer to www.metlife.com.

LEAVE WITH APPLICANT

MetLife®

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

Authorization to Release Health-Related Information to the Producer

Metropolitan Life Insurance Company
General American Life Insurance Company
New England Life Insurance Company
MetLife Investors USA Insurance Company
MetLife Investors Insurance Company
MetLife Insurance Company of Connecticut
Metropolitan Tower 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

▶ _____

Individual Disability Income Insurance Policy Application Process: What's Next?

Thank you for choosing MetLife for your insurance needs. Upon receiving your application materials, we will begin reviewing your application and processing your information. Here is an overview of what you can expect during the underwriting process of your disability application:

Personal History Telephone Interview

- **A MetLife associate may call you within ten days to discuss your application.**
- **The interview should take no more than 15 minutes.**
- **The associate will ask you questions regarding your medical history, occupational duties, and financial information.**
- **If you receive a call from a MetLife associate and you are unavailable, a message will be left requesting you to call (888)838-3444 between 9:00 AM and 7:00 PM EST. Returning this call will help expedite your application processing.**

Request for Financial Documentation

As our disability income policy provides insurance for replacing your income, we may ask you to provide us with proof of your income. This may include:

- **Most recent and prior year W-2 statements**
- **A copy of your most recently filed Federal Income Tax Return Form 1040 with all supporting schedules**
- **Copies of business tax returns with all supporting schedules**

Paramedical Exam

If an examination is required, a representative from one of our paramedical services will call you to schedule an examination at a time convenient for you. The representative will advise you of any special instructions if you are required to fast prior to your examination. At the examination, the technician will:

- **Draw blood**
- **Check your blood pressure and weight**
- **Collect a urine sample**
- **Ask medical questions**

Should you have any additional questions about our underwriting process, please speak with your agent/producer. We thank you for your business, and look forward to speaking with you!

Agent/Producer Name: _____

Telephone number: _____

Agent/Producer Email Address: _____

(Or attach Agent/Producer's business card here! →)