MetLife

Policy Number _____

Application for Life Insurance

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

☐ Metropolitan Life Insurance Company ☐ Metropolitan Tower Life Insurance Company

SECTION I - About the Proposed Insured

For Additional Insureds please complete the **Additional Insureds Supplement** form.

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

Country of Legal Residence | Date of Birth | E-Mail Address

Primary Phone Number | Alternate Phone Number | Preferred Time to Call From ☐AM ☐PM To ☐AM ☐PM | Sex ☐Male ☐Female

Place of Birth | Social Security or Tax ID Number | Earned Annual Income | Net Worth

☐U.S. Driver's License If not licensed, please indicate other form of ID: ☐Passport ☐Government Issued Photo ID

Issuer of ID | ID Number | Issue Date (if any) | Expiration Date (if any)

Name of Employer | Employer City | State | ZIP | Position/Duties

NON U.S. CITIZENS ONLY - Country of Citizenship | Green Card/Visa Type | Expiration Date

Country of Permanent Residence | ID Number | Years in the U.S.

SECTION II - About the Owner

⚠ Complete **ONLY** if the Owner is **NOT** the Proposed Insured.

☐ **OWNER - TRUST / BUSINESS ENTITY -** Name of Entity | Tax ID Number | Trustee / Owner State

☐Trust ☐Business Entity ☐Charity ☐Qualified Pension Plan Complete the appropriate **required** form(s).

☐ **OWNER - OTHER INDIVIDUAL**

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

Country of Legal Residence | Citizenship | Social Security or Tax ID Number | Date of Birth | Phone Number

E-Mail Address | Earned Annual Income | Net Worth | Relationship to Proposed Insured

Please indicate form of ID: ☐U.S. Driver's License ☐Passport ☐Government Issued Photo ID

Issuer of ID | ID Number | Issue Date (if any) | Expiration Date (if any)

☐**Check if ownership should revert to Insured upon Owner and Contingent Owner's deaths.**

SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries, use Section IX - Additional Information.

☐ Check here if the Owner is the Primary Beneficiary.

For Primary or Contingent Beneficiaries who are NOT the Owner, complete the table below.

Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured	Social Security Number (Optional)	Percentage of Proceeds (if not equal)
Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

☐ Check here to include all living and future natural or adopted children of the Proposed Insured as Contingent Beneficiaries. (Name all living children above.)

If a Custodian is acting on behalf of a minor Beneficiary listed above, please use **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

⚠ Federal law states that if someone with special needs has assets over $2,000, they may lose eligibility for government benefits.

SECTION IV - About Proposed Coverage

Check the desired coverage(s).

☐ Universal Life

Product Name

Face Amount*

Riders and Details

☐ Coverage Continuation (UL only)

Disability Waiver:
☐ Specified Premium _____
☐ Monthly Deduction (VUL only)

Death Benefit Option _____

Definition of Life Insurance:
☐ Guideline Premium Test
☐ Cash Value Accumulation Test

Planned Premium
Year 1 _____
Years 2 to _____ _____
Years ____ to ____ _____ (UL only)

☐ Variable Life

Product Name

Face Amount*

Riders and Details

☐ Disability Waiver
Dividend Options:
☐ Paid-Up Additions
☐ Other, please specify:

☐ Automatic Premium Loan Requested

☐ Whole Life

Product Name

Face Amount*

Riders and Details

Disability Waiver:
☐ Convertible ☐ Non-Convertible

☐ Term Life

Product Name

Face Amount*

Riders and Details

ⓘ For a full list of riders and options, please consult with your Producer.
Note: Some riders may require supplement forms to be completed.

For Variable Life products, please complete the **Variable Life Supplement** form.

* If Face Amount is equal to or exceeds $1,000,000, please complete the **Personal Financial Information** form.

ADDITIONAL OPTIONS

One Time (Single) Payment Amount _____

1035 Exchange Amount _____

Requested Policy Date _____

☐ Save Age

POLICY OPTIONS

☐ Alternate Policy: Product, Face Amount and Details _____

☐ Additional Policy: Product, Face Amount and Details _____

☐ Group Conversion Only
☐ Group Conversion Alternative

} Please complete the **Group Conversion Supplement** form for either choice.

SECTION V - About Existing or Applied for Insurance

Does the Proposed Insured or Owner have any existing or applied for life insurance or annuities with this or any other company?

Proposed Insured ☐Yes ☐No
Owner ☐Yes ☐No

If **YES**, please provide details of any existing or applied for **Life** Insurance on the **Proposed Insured** only.

Company	Amount of Insurance	Year of Issue	Status
			☐Existing ☐Applied For
			☐Existing ☐Applied For
			☐Existing ☐Applied For
			☐Existing ☐Applied For

In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ☐Yes ☐No

If **YES,** complete **Replacement Questionnaire** AND any other state required replacement forms or 1035 exchange forms.

If Proposed Insured is financially dependent on another individual, indicate individual providing support:

☐Spouse ☐Child ☐Parent ☐Other _____

Amount of insurance on individual providing support. Existing Insurance _____ Insurance Applied For _____

If Proposed Insured is a minor, are all siblings equally insured? ☐Yes ☐No

If **NO**, please provide details: _____

SECTION VI - About Payment Information

PREMIUM PAYOR

☐Proposed Insured ☐Owner (If NOT the Proposed Insured.) ☐Other (Complete the box below.)

Other Premium Payor Name _____ Social Security or Tax ID Number _____ Relationship to Proposed Insured or Owner _____

Reason this Person is the Payor _____

Permanent Address _____ City _____ State _____ Zip _____

PAYMENT MODE

(Check the appropriate ONE.)

Billing Mode: ☐Annual ☐Semi-Annual ☐Quarterly
☐Monthly Draft per Debit Authorization (See next page.)
☐Monthly Draft per Existing Electronic Payment Number _____

Special Account: ☐Government Allotment ☐Salary Deduction ☐List Bill
If Special Account, provide Employer Group Number (EGN) or List Bill Number _____

INITIAL PAYMENT

Amount Collected with Application _____

Method of Collection:
☐Initial Premium by Electronic Funds Transfer (Must be at least a monthly amount.)
☐Check (Must be at least 1/12 of an annual premium.)

SOURCE OF CURRENT AND FUTURE PAYMENTS (Check **ALL** that apply.)

☐Earned Income ☐Mutual Fund/Brokerage Account ☐Money Market Fund ☐Savings ☐Loans
☐Certificate of Deposit ☐Use of Values in another Life Insurance/Annuity Contract ☐Other _____

DEBIT AUTHORIZATION

⚠ **Available only if the bank account holder is the Owner and/or Proposed Insured.**

All others please complete the **Electronic Payment (EP) Account Agreement** form.

The undersigned ("I") hereby authorize the Company with whom I am completing this application to initiate debit entries through Metropolitan Life Insurance Company to the deposit account designated below, at the Financial Institution named below, using the Automated Clearing House. I authorize:

1. Monthly recurring debits; AND
2. Debits made from time to time, as I authorize.

This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and the Financial Institution a reasonable opportunity to act on it.

Monthly Debit Date: ☐ Issue Date of the Policy

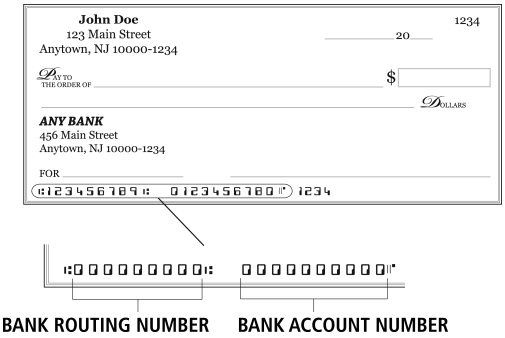
☐ Debit Date on the _____ of each month

Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number _____ Bank Account Number _____

Name of Financial Institution

_____



BANK ROUTING NUMBER BANK ACCOUNT NUMBER

ⓘ Note: Please attach a voided check or deposit slip to Section IX - Additional Information.

We cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services 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).

SECTION VII - General Risk Questions

Use Section IX - Additional Information if necessary.

1. Within the past three years has the Proposed Insured flown in a plane other than as a passenger on a commercial airline or does he or she have plans for such activity within the next year? ☐ Yes ☐ No

If **YES**, please complete a separate **Aviation Risk Supplement** form for the Proposed Insured.

2. Within the past three years has the Proposed Insured participated in or does he or she plan to participate in **any** of the following? ☐ Yes ☐ No

- Underwater sports - SCUBA diving, skin diving, or similar activities
- Racing sports - motorcycle, auto, motor boat or similar activities
- Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities
- Rock or mountain climbing or similar activities
- Bungee jumping or similar activities

If **YES**, please complete a separate **Avocation Risk Supplement** form for the Proposed Insured.

3. Has the Proposed Insured **traveled** or **resided** outside the U.S. or Canada within the **past two years;** or does he or she plan to **travel** or **reside** outside the U.S or Canada within the **next two years?** ☐ Yes ☐ No

If **YES,** please provide details.

Past	Future	Duration (weeks)	Cities and Countries	Purpose
☐	☐			
☐	☐			
☐	☐			

4. Has the Proposed Insured **EVER** used tobacco or nicotine products in any form (e.g., cigars cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)? If **YES,** please provide details. ☐ Yes ☐ No

Product(s)	Frequency / Amount	Date Last Used

5. Has the Proposed Insured **EVER** had a driver's license suspended or revoked, been convicted of DUI or DWI, or in the last five years had any moving violations? If **YES,** please provide date(s) and violation(s). ☐Yes ☐No

6. Has the Proposed Insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? If **YES,** please provide details. ☐Yes ☐No

7. In the past 10 years, has the Proposed Insured been convicted of or pled Guilty or No Contest to a felony? If **YES,** list type of felony, state, and date of occurrence. ☐Yes ☐No

8. Is the Proposed Insured actively at work performing the usual duties of his or her occupation? If **NO,** please provide details. ☐Yes ☐No

SECTION VIII - Personal Physician

☐Check here if Proposed Insured does not have a personal physician.

Physician Name | Name of Practice or Clinic

Street Address | City | State | Zip

Phone Number | Date Last Consulted | Reason | Findings/Treatment Given/Medication Prescribed

SECTION IX - Additional Information

If more space is needed, attach additional sheet(s).

Certification / Agreement / Disclosure

Was a sales illustration provided for the life insurance policy as applied for? ☐ Yes ☐ No

A. If **Yes**, please choose one of the following:

☐ An illustration was signed and **matches the policy applied for**. It is included with this application.

☐ An illustration was shown or provided but is **different from the policy applied for**. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ The sale was made using an illustration with Accelerated Payment.

☐ If illustration was **only shown on a computer screen**, check and complete the details in the box below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) ☐ Male ☐ Female ☐ Unisex
2. Age _____
3. Rating Class (e.g. Standard Non-smoker) _____ ☐ Non-smoker ☐ Smoker
4. Product Name (e.g. GAUL) _____
5. Face Amount _____
6. Dividend Option (Whole Life only) _____

B. If **No**, please choose one of the following:

☐ Producer certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.

☐ **No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Agreement / Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application, paramedical/medical exam, amendment(s), or any supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**
- **If I was required to sign a Notice and Consent for HIV Testing, I have received a copy of that Notice.**

Fraud Warnings

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma, Rhode Island

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

District of Columbia, Tennessee, Virginia, Washington

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

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

- The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
  (a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **or**
  (b) the IRS has notified me that I am not subject to backup withholding.
  (If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)
- I am a U.S. citizen or a U.S. resident alien for tax purposes.
  (If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

ⓘ **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signatures

If not witnessing all signatures, witness should initial next to signature being witnessed and sign below.

Signature(s) of all Proposed Insured(s) | Date | Signed at City, State

▶ _____ _____ _____

▶ _____ _____ _____

(age 15 or over)

Please complete the **Additional Insureds Supplement** or **Child Rider Supplement** form(s) if applicable.

Signature(s) of all Owner(s) (If **NOT** the Proposed Insured.) | Date | Signed at City, State

▶ _____ _____ _____

▶ _____ _____ _____

(age 15 or over)

ⓘ If the Owner is a firm or corporation, include Officer's title with signature.

If Co-Owner or Custodian, please complete the **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

Signature of Parent or Guardian | Date | Signed at City, State

▶ _____ _____ _____

(If Owner or Proposed Insured is under 18, sign here. If not sign above.)

Witness to Signatures

Licensed Producer | Print Name of Producer

▶ _____ _____