MetLife

Metropolitan Life Insurance Company, New York, NY 10166

How You Can Continue Your Group Term Life Insurance – (Portability)

What is Portability?

Portability or porting is an optional feature chosen by your former employer. It allows employees and dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate group policy. The attached medical questions (Statement of Health Form) do not need to be answered to enroll, however you or your spouse/domestic partner must complete them in order to apply for Preferred Life Rates (lower). If approved by MetLife, you will be billed using the Preferred Life Rates (lower).

- If you do not complete the medical questions or do not satisfy MetLife's underwriting requirements, portable coverage will still be issued based on the Non-Preferred Rates (higher).

Once enrolled MetLife will mail you a portable certificate and your initial bill including instructions on how to set up the monthly Electronic Funds Transfer (EFT). The instructions to set up EFT can be found on the back of your bill.

- Your first bill will also include any retroactive premium due from the effective date of your portable coverage and an administrative fee. The current administrative fee is $1.00 per statement if your total portable life insurance coverage is $20,000 or more and $3.00 per statement if your total portable life insurance coverage is less than $20,000. If you only port dependent term life or AD&D, regardless of the amount of coverage, your administrative fee will be $3.00 per statement. If you enroll for EFT the monthly administrative fee is no longer charged

Why is Portable Coverage Important?

Portable coverage provides security and helps eliminate gaps in coverage that you may experience during a time of transition, even if your employment ends.

How Much Time Do I Have To Elect Portability?

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is within 15 days after your coverage ends or is reduced, you will have 31 days after your coverage ended to enroll.

  Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 8	August 31	September 1
July 31	August 15	August 31	September 1

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is given more than 15 days after your coverage ended or is reduced, you will have 45 days from the Date of This Notice to enroll.

  Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 16	September 30	September 1
July 31	August 23	October 7	September 1

- Under **no** circumstances will the option to port be extended past 91 days after the date coverage ended under your former employer's plan.

How Do I Enroll For Portable Life And AD&D Insurance Coverage For Myself And My Dependents?

1. Complete Part B beginning on page 1 of the attached Election of Portable Coverage Form and be sure to answer all sections.

2. Complete the enclosed medical questions (Statement of Health Form) only if:
   a) You are applying for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner; or
   b) You wish to increase the amount of life insurance that you previously had under your former employer's plan, either for yourself, your Spouse/Domestic Partner, or both.

3. Complete, sign and date the Designation of Beneficiary for Your Life Benefits (Part C of the attached Election of Portable Coverage Form).

What Needs To Be Mailed To Complete My Enrollment?

You must return:

a) Your Election of Portable Coverage Form, including information for yourself and if applicable your Spouse/Domestic Partner and Child(ren) (Part A and Part B); and
b) Designation of Beneficiary for Your Life Benefits (Part C)

If you are also **applying** for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner or wish to **increase** your or your Spouse/Domestic Partner's amount of life insurance you must also return the medical questions (Statement of Health) for each person.

- This mailing only contains one set of medical questions (Statement of Health Form). If the medical questions need to be completed for more than one individual, you may make a copy prior to completing or you may call the MetLife Customer Service Center for an additional set of medical questions.

Mail all correspondence to:

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Or Fax to: 1-866-545-7517

Please Note: Certain benefits and provisions that were available under the employer's group policy will no longer be applicable or may be different under your portable coverage.

For questions or assistance, contact the MetLife Customer Service Center toll-free at 1-888-252-3607, Monday – Friday between the hours of 8:00 a.m. and 11:00 p.m. (EST).

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ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is the party designated to maintain records of coverage in effect prior to the Employee becoming eligible to Port. The Recordkeeper may be the Employer, a Third Party Administrator (TPA) or MetLife, a Former Employer, a Plan Administrator, a Group Administrator or a Benefits Administrator.)

1. Immediately upon the Employee's eligibility for Portability, complete Part A below and Column 1 of the table on page 2 and then make a copy of this form.
2. If the Reason for the Portability Eligibility is Death of the Employee or Divorce, complete all of the fields in Part A below with the Spouse/Domestic Partner's information, not the Employee's information. In the column for Amount of Insurance Terminated or Reduced, leave the Employee amounts blank and enter the Dependent Spouse/Domestic Partner/Domestic Partner and Dependent Child(ren) amounts as applicable.
3. Provide the Employee (or Spouse/Domestic Partner in the event of Death of the Employee or Divorce) with the original or mail it to their last known address.
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER	**Date of This Notice (ex. MM/DD/YYYY):**
Employer's Name:	**Group Customer No.:**
Employee Name: (First, Middle, Last)	**Date Coverage Ended or was Reduced:**
Employee's Mailing Address: (Street, City, State Zip)	
Has coverage been assigned? ☐ Yes ☐ No If yes, please specify coverage assigned _____ and attach a copy of assignment form. If coverage has been assigned this form must be mailed to the owner.	
Employee's Basic Annual Earnings: $	**Reason for Insured's Portability Eligibility:**
Recordkeeper's Name:	
Print name of person at Recordkeeper completing Part A:	**Telephone Number:**

Part B – TO BE COMPLETED BY THE EMPLOYEE		
Employee's Home Email Address:	Employee's Home Telephone No.:	
Social Security Number:	Date of Birth: (ex. MM/DD/YYYY)	Sex (M/F):
Note: If you answer Yes to any of the questions below medical questions (Statement of Health Form) must be completed for each person. This mailing only includes one set of medical questions. They may be copied or you may call the MetLife Customer Service Center number for an additional set of medical questions.		
Are you applying for Preferred Life Rates (lower) for yourself? ☐ Yes ☐ No Are you applying for Preferred Life Rates (lower) for your Spouse/Domestic Partner? ☐ Yes ☐ No		
Are you requesting an increase in Life Insurance coverage for yourself? ☐ Yes ☐ No Are you requesting an increase in Life Insurance coverage for your Spouse/Domestic Partner? ☐ Yes ☐ No		

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM

To be Completed by the Recordkeeper (Shaded areas to be completed by the Recordkeeper).		**To be Completed by the Employee** (For each Type of Coverage, please indicate whether you want to continue, discontinue, increase, or decrease the amount of insurance in the shaded column. Select just one option for each Type of Coverage).			
		Continue coverage	**Discontinue coverage**	**Increase coverage**	**Decrease coverage**
Type of Coverage	**Amount of Insurance Terminated or Reduced** Insert the actual $$ amount of coverage (i.e. $50,000)	**I want to continue the same amount of insurance in the shaded column.**	**I want to discontinue the insurance in the shaded column.**	**I want to increase my insurance in the shaded column by the following amount.** [1] (Ex. $25,000 means you want to increase your insurance amount in column 1 by $25,000).	**I want to decrease my insurance in the shaded column by the following amount.** (Ex. $30,000 means you want to decrease your insurance amount in column 1 by $30,000).
Employee [2,3]					
Basic Life	$_____	☐	☐	+ $_____	– $_____
Basic AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional Life	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4]	$_____	☐	☐	+ $_____	– $_____
☐ Employee Only ☐ Employee + Dependents					
Dependent Spouse/Domestic Partner [2,3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$_____	☐	☐	+ $_____	– $_____
Dependent Child(ren) [3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$_____	☐	☐	+ $_____	– $_____

[1] Increases in coverage are available annually and must be in $25,000 increments up to $250,000. For a life insurance increase the employee must complete the medical questions and be approved by MetLife. An increase in AD&D coverage only does not require the insured to complete medical questions.

[2] The maximum amount the employee can continue on a portable basis is $2,000,000. The maximum amount the spouse/domestic partner can continue on a portable basis is $250,000.

[3] In order to port coverage for yourself or your dependents, you must have had that coverage under your former plan at the time of your coverage termination.

[4] AD&D coverage is available without Life Insurance coverage.

[5] The Dependent Spouse/Domestic Partner amount can be greater than the Employee Amount. For Employee and Spouse/Domestic Partner coverage: Spouse/Domestic Partner minimum is $2,500. For Spouse/Domestic Partner only coverage: Spouse/Domestic Partner minimum is $10,000. The Child minimum is $1,000.

[6] Use these fields only when Voluntary AD&D is being requested for the Spouse/Domestic Partner and/or Child because of the death of the Employee or divorce.

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

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM – TO BE COMPLETED BY EMPLOYEE

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

Dependent	Name (First, Middle, Last)	SSN	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Spouse/Domestic Partner				
Child				
Child				
Child				

Part C – TO BE COMPLETED BY THE EMPLOYEE

DESIGNATION OF BENEFICIARY FOR YOUR LIFE INSURANCE (Dependent Life Insurance is payable as specified in the Certificate)
Only check one of the following boxes.

☐ I designate the following person(s) as my primary beneficiary(ies) for my portable term coverage(s). With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

☐ My designation of beneficiary is on a separate form which is signed, dated and attached.

The amount of insurance that is paid to you or your beneficiary will be decreased by any amount of contribution owed to MetLife.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

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

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

FRAUD WARNING

Before signing this election form, please read the warning below:

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

DECLARATION AND SIGNATURE

1. The person signing below acknowledges that they have read and understand the statements and declarations made in this election form.
2. The person signing below acknowledges that they have read the Fraud Warning provided in this election form.

Signature of Insured/Owner

Date Signed (MM/DD/YYYY)

Please Note: MetLife needs to receive the original. The signature and date above may not be altered.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center. If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

TABLE A
LIFE INSURANCE ONLY PREFERRED MONTHLY TERM RATES

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

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

Sample monthly premium calculation for an insured age 45, electing $50,000 of portable coverage

$50,000	÷	$1,000	=	50	x	$0.150	=	$7.50	+	$1.00	=	$8.50
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

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

TABLE B
LIFE INSURANCE ONLY NON-PREFERRED MONTHLY TERM RATES

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

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

Sample monthly premium calculation for an insured age 45, electing $50,000 of portable coverage

$50,000	÷	$1,000	=	50	x	$0.538	=	$26.90	+	$1.00	=	$27.90
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

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

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

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

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

Sample monthly premium calculation for an insured age 45, electing $50,000 of portable coverage

$50,000	÷	$1,000	=	50	x	$0.185	=	$9.25	+	$1.00	=	$10.25
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

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

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

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

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

Sample monthly premium calculation for an insured age 45, electing $50,000 of portable coverage

$50,000	÷	$1,000	=	50	x	$0.573	=	$28.65	+	$1.00	=	$29.65
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

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

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

TABLE E
CHILD MONTHLY TERM RATES

Table E – Sample monthly premium calculation for child(ren) only. An administrative fee will not be charged for the child coverage if you also port your term life insurance. However if only the child(ren) coverage is ported a $3.00 per statement administrative fee will be charged.

$10,000	÷	$1,000	=	10	x	$0.162	=	$1.62
Amount of coverage selected per child	÷	$1,000	=	# of units per child	x	Rate	=	Monthly premium

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

Please Note: Each child is covered for the same premium regardless of the number of children covered under the certificate. For Instance, using the example above, if you have one child covered for $10,000, the amount of premium per month is $1.62. If you have 5 children, each child is covered for $10,000, but the amount of premium per month is still $1.62. A billing fee may also apply.

TABLE F
AD&D INSURANCE ONLY MONTHLY TERM RATES

Table F – Sample monthly premium calculation of AD&D Premium For Insured Only. An administrative fee will not be charged for AD&D coverage if you also port your term life insurance. However if only AD&D coverage is ported a $3.00 per statement administrative fee will be charged.

$50,000	÷	$1,000	=	50	x	$0.035	=	$1.75
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate	=	Monthly premium

AD&D TERM RATES

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

VAD&D TERM RATES

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

INSTRUCTIONS

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

INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee or the Employee's Spouse/Domestic Partner.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. Complete the Statement of Health form and sign where indicated by an arrow.
2. Sign the Authorization form where indicated by an arrow.
3. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right.

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoi@metlife.com.

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Employee)

Name of Group Customer/Employer/Association	Group Customer #		
Trustee of the MetLife Group Life and Health Insurance Program Trust	**123470**		
Street Address	City	State	Zip Code
500 Delaware Ave., 11th floor	**Wilmington**	**Delaware**	**19801**

EMPLOYEE INFORMATION (To be Completed by the Employee)

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

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)			Relationship to Employee ☐ Self ☐ Spouse/Domestic Partner	☐ Male ☐ Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified or ☐ issued other than as applied for? Indicate reason _____	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐	☐
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
10. **For residents of all states except CT,** please answer the following question**:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **For CT residents, please answer the following question:** To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Indicate type _____	☐	☐
b. stroke or circulatory disorder? Indicate type _____	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss? Indicate type _____	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type _____	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
u. sleep apnea? Indicate type _____	☐	☐

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

Personal Physician Information

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (____) ____–____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (____)____-_____

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

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

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

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

Maine, Tennessee and 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 a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

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

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

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

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

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

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

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*;
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

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

Sign Here

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

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

Sign Here

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

AUTHORIZATION

METROPOLITAN LIFE INSURANCE COMPANY

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about the proposed insured including employment and occupational information;
- medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
- information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
- motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at [P.O. Box 14069, Lexington, KY 40512-4069,] and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

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

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

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

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

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)
Relationship of Personal Representative		