

**STATEMENT OF HEALTH FOR ENROLLMENT FOR EMPLOYEE OR DEPENDENT GROUP INSURANCE**

**To be Completed by the Employer**

|   |       |                 |                           |                        |
|---|-------|-----------------|---------------------------|------------------------|
| Employer Name   |       | Customer Number | Reporting Location Number |                        |
| Employer's Street Address   |       | City            | State                     | Zip Code               |
| Employee Name   | First | MI              | Last                      | Social Security Number |
| <b>Insurance Requested (To be completed for each Applicant)</b>   |       |                 |                           |                        |
| <input type="checkbox"/> Basic Life (or Core) <input type="checkbox"/> Optional Life (or Buy-Up) <input type="checkbox"/> Dependent Life (or Buy-Up) <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability |       |                 |                           |                        |
| Additional Amount of Life Insurance Subject to Medical Underwriting \$ _____  |       |                 |                           |                        |
| Insurance is for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child                      Enrollment Year: _____  |       |                 |                           |                        |

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

|   |                |                |       |                |                  |  |                          |
|---|----------------|----------------|-------|----------------|------------------|--|--------------------------|
| Insurance is for:<br><input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child |                | Applicant Name | First | MI             | Last             | <input type="checkbox"/> Male<br><input type="checkbox"/> Female | Date of Birth (mm/dd/yy) |
| Street Address  |                |                | City  |                |                  | State  | Zip Code                 |
| Daytime Phone Number<br>( )   | E-mail Address |                |       | State of Birth | Country of Birth |  |                          |

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

1. Height            feet            inches                      Weight            lbs.

2. Are you now: Yes    No

a. pregnant?    

b. taking prescribed medications or on a prescribed diet? If "yes," list: \_\_\_\_\_    

c. receiving or applying for any disability benefits including workers' compensation?    

3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?    

4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug?    

5. Have you ever been diagnosed, treated, tested or given medical advice by a physician or other health care provider for:

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

6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?    

7. Personal Physician: \_\_\_\_\_ Date and reason for last visit : \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number \_\_\_\_\_

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

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

**Employee – Make A Copy For Your Records and  
Return the Completed Form to MetLife**

**Declaration** — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

**Authorization To Collect and Disclose Information** — for underwriting and claim purposes, I **permit**: any physician, hospital, clinic, other medical related facility, employers and group policyholders, contractholders or benefit plan administrators:

To disclose to Metropolitan Life Insurance Company (“MetLife”) and any benefit plan administrators, consumer reporting agencies, [the Medical Information Bureau, Inc. (MIB),] attorneys, and independent claim administrators acting on MetLife’s behalf, any and all medical data that you may have on the person proposed for insurance. I specifically authorize disclosure of findings on: medical care or surgery; psychiatric or psychological care or examinations; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable diseases may be controlled by various laws and regulations. I consent to disclosure of such information to MetLife but only in accordance with laws and regulations as apply to me. MetLife may collect, use and re-disclose any information in its possession, including medical information, as indicated in the Consumer Privacy Notice which accompanies this form.** I understand that I may revoke this authorization at any time. If I do not, it will be valid for the lesser of: 24 months from the date I sign it, the term of insurance under the policy or the duration of a claim. A photocopy of this authorization is as valid as the original form. You or your authorized representative have a right to receive a copy of this authorization on request.

**Fraud Warning:**

If you are applying for insurance under a policy issued in one of the following states, **or** if you reside in one of the following states, note the following applicable warning:

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

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

**Kansas and Massachusetts:** 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 may subject such person to criminal and civil penalties.

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

**Oklahoma:** 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.

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

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

If you are applying for coverage under a self-funded plan or insurance under a policy issued in any state other than those listed above, **or** if you reside in any state other than those states listed above, note the following warning:

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

|  |      |
|--|------|
| (Employee must always sign)  |      |
| Signed   | Date |
| [Person for whom insurance is being requested if other than Employee and at least 18 years of age) |      |
| Signed   | Date |

## MetLife's Consumer Privacy Notice

### Notice To Employee

The following Consumer Privacy Notice is to be printed and kept with your records at all times. Upon completion of the Statement of Health form, you are to retain a copy of the fully-completed form and return the original to MetLife.

We will evaluate your request for insurance to see whether you are eligible for this insurance. We will first review all of the information furnished by you on this form. We may confirm or add to this information in the ways described in this notice. All applicants are treated in a fair way.

We will tell you if we cannot give you the insurance you asked for. We will always tell you in general terms the reason for our decision. Unless prohibited by applicable laws, we will usually provide you with specific details regarding our decision. Otherwise, we will disclose the information through the licensed physician you choose.

### Information Collection

This form is our main source of information. To evaluate your request properly, we may obtain additional data from third parties about any person proposed for insurance. For example, we may:

- Ask you to have a medical evaluation, which may include tests such as an electrocardiogram.
- Ask physicians, hospitals, or other medical care providers to confirm or add to the medical data you have given us.
- Obtain a report from a consumer reporting agency. Information about this report and the rights you have under Federal law and your state's law, if any, is provided below. In addition, we may request information from you or from third parties from which we will be able to draw conclusions about your personal characteristics such as your habits or your health.

### Information Maintenance and Use

We treat the information we have about you in a confidential way. We will use it for business purposes relating to the insurance provided under your employer's employee benefit plan or plans. For example, it may be used when we evaluate any claims you submit for benefits under your employer's benefit plan(s).

### Information Disclosure

In most cases, the information we have about you will be sent to third parties only if you authorize us to do so. For example, under the Authorization which you have completed on the Statement of Health form, the information may be sent to our reinsurers and others who perform business services for us.

In some cases, where disclosure is required by law and/or is necessary for the conduct of our business, we may send the information to third parties without your consent. For example, it may be given to other insurers or insurance support organizations when we believe it may help us detect or prevent fraud or misrepresentation. It may be disclosed to a medical professional for the purpose of verifying insurance or benefits, informing you of medical problems which you may not know about, or for audits used to verify information provided to us by the medical professional. The information may also be disclosed to an insurance regulatory authority or to a law enforcement or other governmental authority when we believe it is necessary to protect our interests, or to prevent or prosecute fraud against us, or if we believe that illegal activities have been conducted by you. This information may also be used for the purpose of conducting actuarial or research studies or provided to our affiliate in connection with an audit of our company. This information can also be provided to your employer for the purposes of reporting claims experience or if your employer requests an audit of our company.

### Access and Correction of Information

Upon your written request, we will make the information we have about you available to you. Medical information will be provided to you or disclosed through the licensed physician you choose or as otherwise required by law.

We will also permit you to see and copy such information pertaining to you or to obtain a copy of such information by mail, whichever you prefer. We will also disclose to you the identity of any third party to which we have disclosed this information within the past two years. If our files do not reflect the identity of third parties to whom we have disclosed this information, we will inform you of the identity of third parties to whom we normally disclose such information.

If you feel that the information in our files is wrong or incomplete, you may let us know and if we agree with you, we will correct, amend, or delete the portion of the information which you dispute. If we do not agree with you, we will notify you of our refusal to make this correction, amendment, or deletion, the reasons for our refusal and your right to file a statement of dispute with us.

If we correct, amend, or delete the information as you request, we will notify you and we will furnish the correction, amendment or deletion to any person who you specifically designate who may have received the information within the preceding two years, or any organization that furnished the corrected, amended, or deleted information to us, or to any third party whose primary source of information is insurance companies if the third party has received information from us within the preceding seven years.

If you choose to file a statement of dispute with us, you may provide us with a statement setting forth the information which you think is correct, relevant or fair, or a statement of the reasons why you disagree with our refusal to correct, amend, or delete the disputed information. We will file your statement with the disputed information and provide a means by which anyone viewing the disputed information will be made aware of your statement and have access to it. In addition, in any subsequent disclosure by us of the disputed information, we will clearly identify the matter or matters in dispute and provide your statement along with the information being disclosed. Finally, we will furnish your statement to any third party to whom we would provide a correction, amendment, or deletion of information as referenced above.

### Consumer Reports

MetLife may ask an independent source to confirm and add to the information which you have provided in this Statement of Health form. This report is known as a consumer report. Upon your request, we will inform you whether or not we requested a consumer report in connection with your Statement of Health and if such a report was requested, we will provide you with the name and address of the consumer reporting agency that furnished the report to us. You may inspect that report or obtain a copy by contacting the reporting agency. The information obtained from a consumer report may be retained by the consumer reporting agency and disclosed to other parties.

#### MIB, Inc. (Medical Information Bureau)

We may make brief reports to MIB. The reports will include certain medical and non-medical information which affects the insurability of any person for whom insurance is sought.

MIB is a nonprofit organization of life insurance companies. It operates an information exchange for its members. If you apply to some other member company for life or health insurance, or send in a claim for benefits, MIB may supply that company with any information in its file.

If you ask, MIB will arrange to disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you may get in touch with MIB and ask them to correct it as provided in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112. MIB's telephone number is (617) 426-3660.