

Life Insurance Application and Forms Package

Table of Contents and Instructions

Form Name	Form Number	Instructions/Notes
Application for Life Insurance	ENB-7-07-CA	Application for Individual Life Insurance for all MetLife affiliated companies. Signatures Required
Authorization	EAUTH-07	Proposed Insured's authorization for release of information to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Signatures Required
Notice and Consent for HIV-Related Testing	EHIV-04	Notice and Consent Authorization form for HIV related testing. Note: Use the applicable form for each Proposed Insured's state of residence. Signatures Required
Producer Identification & Certification	EPID-54-07	This is to be completed by the Producer attesting to completion of the application and certification of Owner identity. Signatures Required - Producer and Agency Management
Personal Financial Information	EFIN-05	To be completed when the amount of coverage is \$1,000,000 or over. Used to obtain information about income and assets/liabilities of the Proposed Insured(s).
Medical Supplement	EMED-48-07-CA	This form is to be completed by the Proposed Insured regarding his/her health for underwriting purposes. Note: Completion is optional if a full Paramedical/ Medical Exam is required. Best practice is to answer all medical questions to enable the underwriter to promptly begin the underwriting process.

What Customers Should Know

IDENTITY VERIFICATION:

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who applies for life insurance.

WHAT THIS MEANS FOR YOU:

When you apply for a policy, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

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What Producers Should Know

- Incomplete Applications may delay processing.
- Complete all required sections and obtain all signatures and titles (where required).
- Do not use pencil to complete this application or use "white out" to make changes. If a change is made to an answer, the respondent must initial the change.
- When a replacement is involved or if the policy state has adopted a replacement regulation, the appropriate state required replacement form(s) must be signed and dated on, or prior to, the Application date.
- The NAIC Replacement Notice (EREPLDIS-NAIC) must be completed and signed in certain states if either the Proposed Insured or the Owner has any existing life insurance policies or annuity contracts even if they are not replacing this coverage.
- While completion of the Medical Supplement (EMED-48-07-CA) is not required if the Proposed Insured is being examined, answering all medical questions (including the full name, address and phone number for each physician consulted) is good field underwriting practice and will enable the underwriter to promptly begin the underwriting process.
- Complete and sign the Producer Identification & Certification form.
- Social Security number of the Beneficiary is an optional field. However, this information is valuable in helping us locate Beneficiaries at time of claim.
- Complete all Supplements and Questionnaires indicated by the applicant's selection in this Application, and submit them WITH this Application.
- We do not accept cash, traveler's checks, credit cards or money orders as a form of payment for variable life products.
- Use 'Other' as source of funds if the contract is to be funded in full or in part with monies from a reverse mortgage or home equity loan. If this is one of several "other" fund sources, please provide details in the Section IX - Additional Information.
- When selecting List Bill as the method of payment, you must also indicate the bill frequency by checking the appropriate box (annual, semiannual, quarterly). In the event the frequency is monthly, please indicate that in Section IX in this application.
- For details regarding products and riders, as well as a forms inventory for the new business application process, please review the producer tools and the product section of the Producer Portal.
- Additional Insureds must complete the Additional Insureds Supplement for each life proposed for coverage.

Legend for Symbols

- ① For Your Information
- Refer to Supplement
- Attention

Policy Number _____

Application for Life Ins	urance					
Company (Check the appropriate The Company indicated in this sec referred to as " the Company ".	tion is 🛛 🗌 New Eng	itan Life Insurance Co land Life Insurance Cc nvestors Insurance Co	ompany 🗌		merican Life Insu nvestors USA Insu	
SECTION I - About the Pre	oposed Insured					
For Additional Insureds please co	mplete the Additional I	nsureds Supplemer	nt form.			
First Name	Middle	Name Las	t Name			
Permanent Address		City			State	Zip
Country of Legal Residence	Date	of Birth	E-Mail A	ddress		
Primary Phone Number	Alternate Phone Number	Preferred Time to Call	From	AM	To 🗌 AN	ı Sex ⊡ Male
Place of Birth	Social Security or Tax	ID Number Earned	Annual Incom	e	Net Worth	_
U.S. Driver's License If	not licensed, please indica	ate other form of ID:	Pass	port	Government	Issued Photo ID
Issuer of ID	ID Number	lss	ue Date (if any)	Expiration D	Date (if any)
Name of Employer	Employer City	State	Zip	Pos	ition/Duties	
NON U.S. CITIZENS ONLY - Co	ountry of Citizenship	Green Card	/Visa Type		Expiration	Date
Country of Permanent Residence		ID Number			Years in th	ie U.S.
SECTION II - About the O	wner 🛕 Comple	ete ONLY if the Owne	r is NOT the P	roposed li	nsured.	
OWNER - TRUST / BUSINE	ESS ENTITY - Name of En	itity Tax ID	Number		Truste	ee / Owner State
Trust Business Entit		fied Pension Plan	Complete the	e appropri	ate required for	rm(s).
First Name		1iddle Name	Last Name			
Permanent Address		City			State	Zip
Country of Legal Residence	Citizenship S	ocial Security or Tax I	D Number Da	ate of Birt	h Phone	Number
E-Mail Address	·	Earned Annual Incon	ne Net Worth	1	Relationship to	Proposed Insured
Please indicate form of ID:	U.S. Driver's L	icense	Passport		Governmer	nt Issued Photo ID
Issuer of ID	ID Number		lssue Date (if	any)	Expiratior	n Date (if any)
Check if ownership sl	nould revert to Insured	d upon Owner and	Contingent	Owner's	deaths.	
						1 of 1

SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries	use Section IX - Additional	Information.
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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.

A 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 📋 Variable Life 🗎	🗌 Whole Life	🗌 Term Life					
Product Name	Product Name	Product Name					
Face Amount*	Face Amount*	Face Amount*					
Riders and Details	Riders and Details	Riders and Details					
Coverage Continuation (UL only)							
Disability Waiver:	Disability Waiver	Disability Waiver:					
Specified Premium	Dividend Options:	Convertible Non-Convertible					
Monthly Deduction (VUL only)	Paid-Up Additions						
Death Benefit Option	Other, please specify:						
Definition of Life Insurance:	Automatic Premium Loan Requested						
Cash Value Accumulation Test Planned Premium Year 1	For a full list of riders and options, please Note: Some riders may require supplement	e consult with your Producer. ent forms to be completed.					
	For Variable Life products, please complet	te the Variable Life Supplement form.					
Years 2 to Years to (UL only)	* If Face Amount is equal to or exceeds \$1, Financial Information form.	000,000, please complete the Personal					
ADDITIONAL OPTIONS One Time (Single) Payment Amount 1035	Exchange Amount Requested Po	licy Date 🗌 Save Age					
POLICY OPTIONS	OLICY OPTIONS						
Alternate Policy: Product, Face Amount a	nd Details						
Additional Policy: Product, Face Amount a	nd Details						

Group Conversion Only

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

Group Conversion Alternative

SECTION V - About Existing or App	ied for Insurance				
Does the Proposed Insured or Owner have any annuities with this or any other company?	existing or applied for life insu	rance or	Proposed Owner	d Insured 🗌 Ye	
If YES , please provide details of any existing or	applied for Life Insurance on	the Proposed I	nsured <u>only</u> .		
Company		ount of Ye	ear of Issue	Status	
				Existing	Applied For
				Existing	Applied For
				Existing	Applied For
				Existing	Applied For
In connection with this application, has there b transaction; loan; withdrawal; lapse; reduction (except conversions) involving an annuity or oth	or redirection of premium/con ner life insurance?	sideration; or cha	inge transactio	on Y	es 🗌 No
	-	· ·		-	
If Proposed Insured is financially dependen		-		port:	
Spouse Child Parent					
Amount of insurance on individual providing			Insurance A	Applied For	
If Proposed Insured is a minor, are all siblings If NO , please provide details:	equally insured?	Yes 🗌 No			
SECTION VI - About Payment Inform	nation				
PREMIUM PAYOR					
	OT the Proposed Insured.)	Othe	er (Complete t	he box below.)	
Other Premium Payor Name	Social Security or Tax	ID Number Re	lationshin to F	Proposed Insured of	r Owner
		ne			
Reason this Person is the Payor					
Permanent Address	City			State Zip	
PAYMENT MODE Billing Mode: (Check the appropriate ONE.)	 Annual Monthly Draft per Deb Monthly Draft per Exis 		See next page.)	nterly
Special Account	: 🔲 Government Allotment	Salary	Deduction	🗌 List	Bill
	nt, provide Employer Group N	umber (EGN) or L	ist Bill Numbe.	r	
INITIAL PAYMENT	Method of Collection:				
Amount Collected with Application	 Initial Premium by Elec Check (Must be at leas 			at least a monthly a	amount.)
SOURCE OF CURRENT AND FUTURE PAYN	IENTS (Check ALL that apply	.)			
Earned Income Mutual Fund	/Brokerage Account	Money Market F	und 🗌 🗄	Savings	Loans
Certificate of Deposit Use of Value	s in another Life Insurance/An	nuity Contract		Other	
					3 of 11

^{1%1%2%07%4%10076%7%3%14%}Z

DEBIT AU	JTHOR	IZATION Available o				the Owner and/oı t (EP) Account Ag	
The undersigned ("1") 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.							
			and the	Financial Instit	ution a reasona	ble opportunity to a	ct on it.
Monthly Debit [Date:	Issue Date of the Policy			John Doe 123 Main Street		1234
		Debit Date on the o	of each n	nonth	Anytown, NJ 10000-1234	ŧ.	\$
Bank Account T	ype:	Checking Savings			ANY BANK 456 Main Street Anytown, NJ 10000-1234		- Dollars
Bank Routing N	lumber	Bank Account Num	ıber		FOR	1123456780 ") 1234	
Name of Finan	Name of Financial Institution						
					ANK ROUTING NUM	BER BANK ACCOUNT	
🕄 Noto: Ploa	so attach i	a voided check or deposit slip to	Soction I			BER BANK ACCOUNT	NOMBER
		king services from starter checks				tual fund chocks. We	cannot ostablish
		reign banks UNLESS the check is					
		ne must be on the check).	51		J	·	-
SECTION VI	l - Genei	ral Risk Questions	Jse Secti	on IX - Additior	nal Information	if necessary.	
1 Within the na	ast three ve	ears has the Proposed Insured flo				•	
		have plans for such activity with			n us u pussenge		🗌 Yes 🔲 No
🗎 If YES , pl	ease comp	lete a separate Aviation Risk S	upplem	nent form for t	he Proposed Ins	sured.	
		ears has the Proposed Insured pa	rticipate	d in or does he	or she plan to p	oarticipate in any	
of the follow		CLIPA diving skin diving or sim	ilar activ	itioc			🗌 Yes 🗌 No
	-	CUBA diving, skin diving, or sim cycle, auto, motor boat or simila					
5 1		, hang gliding, parachuting, ball			ies		
		nbing or similar activities	-				
		milar activities	_			_	
🗎 If YES , pl	ease comp	lete a separate Avocation Risk	Supple	ement form for	r the Proposed I	nsured.	
		ed traveled or resided outside r reside outside the U.S or Cana				vo years; or does h	e 🗌 Yes 🗌 No
If YES , pleas			mull		- ,		
Past	Future	Duration (weeks)		Cities and Cou	Intries	Pu	rpose
4 Has the Prop	osed Insur	ed EVER used tobacco or nicotin	e produc	ts in any form	(e a cinars cin	arettes cigarillos	
		, nicotine patches, or nicotine gu				areas, againos,	🗌 Yes 🗌 No
		Product(s)			Frequency / Am	ount	Date Last Used
	1000000000000000000000000000000000000						

5.	. In the past 10 years, has the Proposed Insured 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	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
7.	 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

Physician Name			Name of Pi	ractice or Clinic		
Street Address			City		State	Zip
Phone Number	Date Last Consulted	Reason		Findings/Tre	atment Given/Mec	lication Prescribed
SECTION IX - Additi	onal Information	more space	e is needed, a	ttach additional she	et(s).	

Certification / Agreement / Disclosure

Was a sales illustration provided for the life insurance policy as applied t	or?	🗌 Yes 🔲 No				
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	If illustration was only shown on a computer screen , check and complete the details in the box below.					
of the illustration was provided. An illustration conforming to the p	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)	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.

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.

S	gnatures 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 18 or over)						
	Please complete the Additional Insureds Suppleme	nt or Child Rider Sup	plement form(s) if applicable.				
	Signature(s) of all Owner(s) (If NOT the Proposed Insured.)	Date	Signed at City, State				
►							
►	(
	(age 18 or over) ③ If the Owner is a firm or corporation, include Officer's tit ◎ If Co-Owner or Custodian, please complete the Co-Own	5	r 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 Produce	r				

Authorization

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

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any pharmacy or pharmacy-related service organization; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
 - personal information and data;
 - entire medical file for the last ten (10) years, including medical information, records and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
 - information related to alcohol and drug abuse and treatment;
 - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

Signatures

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the Company as described in the Company's Privacy Notice, a copy of which was given to me.
- 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; any Company employee; or any affiliate or independent contractor

who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.

- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. Health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization cannot condition treatment or payment for treatment or other benefits on my signing it.
- This Authorization will end 24 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, Privacy Office, PO BOX 489, Warwick, RI 02887-9954 and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.
- A photocopy of this form is as valid as the original form.

Pri	int Name of Proposed Insured			Date of Birth
	First	Middle	Last	
If P	Proposed Insured is under 18, the [Parent or Guardian is t	o sign on line for such child.	
Sig •	nature of Proposed Insured	Date	Signed at City, State	
	witness, I attest to having observe tness to Signature	d all parties sign in my presence.		
▶	-			

1%1%2%07%4%10174%7%1%1%2%

MetLife

Proposed Insured:

		First Name	Middle Name	Last Name
Notice and Consent For HI	V-Related Testing			Company Copy
Company (Check the appropriate ONE The Company indicated in this section i referred to as " the Insurer ".		13045 Te pany 🗌 MetLife	I American Life Insurance sson Ferry Road, St. Louis, MO Investors USA Insurance are Ave., Suite 900, P.O. Box 2	63128
	MetLife Investors Insurance Comp 13045 Tesson Ferry Road, St. Louis, MO 63		olitan Tower Life Insura Avenue, New York, NY 10166	

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:

 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/antigenpositive 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.

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.

1%1%2%07%4%10055%7%1%14%U

eF

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)

First		

La

Middle

Signature of Proposed Insured or Parent/Guardian

Date

· ___

Witness

eF

Producer Identification a	& Certification	\land Incomplete information ma	ay delay	your app	lication.
1. What is the purpose of insurance? (Cl Estate Planning Executive Bonus Business Needs - Other	heck ALL that apply.) Charitable Giving Split Dollar Income Protection	Qualified Plan Mortgage Protection Private Split Dollar Other Other		,	//Sell / Person
2. Method used to arrive at the Face Am	ount Recommendation?				
Profiles Needs Analysis	Human Life Value	GSIB Proposal Other			
3. Was this sale made using an illustration4. Is this insurance a replacement?	on with Accelerated Premium	n? If YES , please indicate number of years.	Yes Yes	yrs.	🗌 No
5. Have you completed and attached the	required replacement forms?	?	Yes	No	N/A
6. Have you attached the Internal Revenue	ue Code Section 1035 form?		Yes	No No	N/A
7. Have the following documents been d Privacy Notice HIV Notice and Consent Form Compensation Disclosure Notice* Debit Authorization Disclosure ABR/ADBR Disclosure Statement *Only required for business sold by Agency	Yes No Yes No N// Yes No N//	A Military Disclosure A Current prospectus for variable	 Yes Yes Yes Yes 	 No No No No 	□ N/A□ N/A□ N/A
8. Did you use only sales material appro	wed for use by the appropriat	te Company?	Yes	🗌 No	
9. Did you see all persons to be insured	on the date the application v	vas taken? Yes No If NO, why not?			
10. Do any of the Beneficiaries (Primary	or Contingent) or their deper	ndents have special needs?	Yes	🗌 No	
11. Are you related to the Proposed Insu	ured(s)? 🗌 Yes 🗌 No	If YES, indicate relationship			
12. Are the Proposed Insured(s) and Ow	ner(s) interested in electronic	c delivery of product reports?	Yes	No No	
Certification of Owner Identity:					
		tive(s) of the entity and reviewed the appropriate ide ne identity of the Owner(s)/legal representatives of th		documents.	

I did not meet in person with the Owner(s)/legal representative(s) of the entity or I was otherwise unable to personally review the Owner(s)/entity's identification documents. I certify that, to the best of my knowledge, the Owner(s)/entity's identification information provided by the legal representative(s) either by mail or phone is accurate.

I certify that I have truly and accurately recorded on all parts of this application the information supplied by the Proposed Insured(s) and/or the applicant(s). As noted in question #9 above, I have personally observed each Proposed Insured and applicant. Apart from any admissions recorded on the application or any additional comments that I have supplied to underwriting, each appears to me to be healthy. The purpose of this sale has been discussed with the Owner(s) and I believe this application to be an appropriate recommendation.

Producer Name (Please Print FULL Name)	Sales Office/ Agency Number/ID	Producer Number/ID	Commissi 1st Year	on Split % Renewal	Amount of GDC (for MLD only)

Signatures

Producer Identification & Certification

Name of Producer	Producer Signature	Date
I have personally reviewed this application for appropriaten	ess of sale. The Producer was appropriately licensed and appointed on the d	ate the application was signed.
Name of Agency Manager or Designee	Agency Manager or Designee Signature	Date
Broker/Dealer or Home Office use only Suitability Review of Variable Products	Registered Principal Signature	Date
Annualized Commissions - Life Independent Pro	oducers ONLY Does the Producer wish to annualize commissions?	Yes No
If YES , signature of Producer's Manager (GA/MGA/BGA) is required.	GA/MGA/BGA Signature	Date
		11 of 11

1%1%2%07%4%10214%7%1%14%R

Policy Number _____

Personal Financial Information	To be completed when the amount of coverage is \$1,000,000 and over
Company (Check the appropriate ONE.)The Company indicated in this section is referred to as "the Company".	Metropolitan Life Insurance Company
SECTION I - Income	
Proposed Insured	Additional Proposed Insured
First Name Last Name	
Annual Earned Income (in US dollars)	Annual Earned Income (in US dollars)
Salary or Draw \$	
Bonus/Commissions \$	Bonus/Commissions \$
Other Earnings \$	Other Earnings \$
Source	Source
Total Earned Income \$	Total Earned Income \$
Spouse's Income \$	Spouse's Income \$
Annual Unearned Income (in US dollars)	Annual Unearned Income (in US dollars)
Dividends/Interest \$	Dividends/Interest \$
Net Rentals \$	Net Rentals \$
Other Unearned \$	Other Unearned \$
Source	Source
Total Unearned Income \$	Total Unearned Income \$
SECTION II - Assets and Liabilities	
Proposed Insured	Additional Proposed Insured
Assets (in US dollars)	Assets (in US dollars)
Cash \$	Cash \$
Real Estate \$	Real Estate \$
Business Equity \$	Business Equity \$
Stocks/Bonds \$	Stocks/Bonds \$
Other Assets \$	Other Assets \$
Total Assets \$	Total Assets \$
Liabilities (in US dollars)	Liabilities (in US dollars)
Mortgages \$	Mortgages \$
Personal Loans \$	Personal Loans \$
Other \$	Other \$
Total Liabilities \$	Total Liabilities \$
Net Worth \$	Net Worth \$
(Total Assets - Tota	l Liabilities) (Total Assets - Total Liabilities)

1 of 1

Medical Supplement

Company (Check the appropriate ONE.)	Metropolitan Life Insurance		can Life Insurance Company	
The Company indicated in this section is	New England Life Insurance	, , _	ors USA Insurance Company	
referred to as "the Company".	MetLife Investors Insurance			
This supplement will be at	tached to and become part	of the application with wh	nich it is used.	
SECTION I - Medical Questions	Λ If more space is needed	d, attach additional sheet(s).		
() If FULL PARAMEDICAL/MEDICAL EXAM is re	equired, completion of this Medi	cal Supplement form is OPTIO	NAL.	
Proposed Insured - First Name	Middle Name L	ast Name		
1. Please provide Proposed Insured's height ar	d weight: Height (ft. in.)	Weight (lbs.)	,	
Has the Proposed Insured experienced a cha	ange in weight greater than 10 p	ounds in the past 12 months?	🗌 Yes 🔲 No	
If YES, please specify: Pounds Lost	Pounds Gained	Reason		
2. Has the Proposed Insured, within the last 10 professional for any of the following? If YE :	5, please check ALL that apply a			
		Parkinson's Disease	V. 🗌 Lupus	
	1 2	 Alzheimer's Disease Memory Loss 	W. Anemia	
	Seizures R.		X. Depression / Anxiety Y. Depression / Anxiety	
	Stroke / TIA S.			
	Paralysis T.	Hepatitis		
	Multiple Sclerosis U.	Arthritis		
Letter Name of Health Professional (Include City & State)	Date / Duration of II	ness Diagnosis	/ Treatment / Medication	
3 . Other than as indicated above, has the Prop of any of the following? If YES , please chec			der 🗌 Yes 🗌 No	
A. 🔄 Heart	G. Prostate	M. 🗌 Thyroid / O)ther Glands	
B. 🗌 Arteries / Veins	H. Reproductive Organs	N. 🗌 Eyes		
	I. Brain / Nervous System	0. 🗌 Ears / Nose	e / Throat	
D. 🔄 Gastrointestinal / Digestive System E. 🥅 Liver / Pancreas	J. D Blood K. Lymph Nodes	P. 🗌 Skin	Donas / Joints	
F. 🗌 Kidney / Bladder	L. Immune System		Bones / Joints / Psychological Disorder	
			r sychological Disoraci	
Letter Name of Health Professional (Include City & State)	Date / Duration of I	Iness Diagnosis	/ Treatment / Medication	
1 of 2				

4	Conter than as indicated previously, within the past five years, has the Proposed Insured had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility?	🗌 Yes 🗌 No
5	b. Is the Proposed Insured currently receiving any treatment or taking any prescription or nonprescription medications or supplements, as prescribed by a member of the medical profession?	🗌 Yes 🗌 No
6	b. Does the Proposed Insured have any surgery, medical tests, treatment or visits with a health professional scheduled in the next six months?	🗌 Yes 🗌 No
7	. Has the Proposed Insured ever been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)?	🗌 Yes 🗌 No
8	. Has the Proposed Insured ever tested positive during a medical examination for life insurance for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus?	🗌 Yes 🗌 No
9	. Has the Proposed Insured ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health professional?	🗌 Yes 🗌 No
10	D. Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health professional or support group?	🗌 Yes 🗌 No

If **YES**, please provide details in table below for Questions 4 - 10.

Number	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

SECTION II - Family History

Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer; or kidney disease? If **YES**, please provide details in table below.

🗌 Yes 🗌 No

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			



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IMPORTANT DOCUMENTS

Regarding Your Insurance Application

NOTICE AND CONSENT FOR HIV-RELATED TESTING As part of the application process you may have signed an identical copy of this document which will be kept in the Company files. By signing it you agreed that HIV testing may be performed and that underwriting decisions may be based on the test results. This copy is provided to you for your records so you may understand all the implications of a positive test result.	EHIV-04
PRIVACY NOTICE This Notice describes how we treat the information we obtain about you or any persons to be insured under the policy applied for. Please read it carefully so that you understand our privacy policy and know your rights under the law.	ECPN-07
LIFE INSURANCE BUYER'S GUIDE This guide can help you when you shop for life insurance.	EBG
TEMPORARY INSURANCE AGREEMENT If you gave your Producer an advance payment equal to at least 1/12 of an annual premium and the Producer signed page 2 of the Temporary Insurance Agreement, this document serves as your receipt and explains the conditions of temporary insurance. Please take a few moments to become familiar with these conditions.	ETIA-8-07
BANK DRAFT DISCLOSURE If you, as the Owner or Proposed Insured, chose to authorize electronic debits in the Application for Life Insurance, your Producer will provide this Disclosure. It provides important information.	DEBITDISC
ACCELERATION OF DEATH BENEFIT RIDER (ADBR) SUMMARY AND DISCLOSURE STATEMENT — If you chose the Acceleration of Death Benefit Rider, your Producer will provide this Statement. It provides a brief description of the important features of the rider including benefits, limitations and exclusions.	EP-1280-04

Producer:

PLEASE REMOVE the Temporary Insurance Agreement from the package if advance payment was not collected at the time of application.

PLEASE REMOVE the Bank Draft Disclosure if Electronic Payment was not selected.

PLEASE REMOVE the Acceleration of Death Benefit Rider (ADBR) Summary and Disclosure Statement if ADBR was not selected.

EHIV-04 (05/05)

MetLife

Notice And Consent For HIV-Related Testing

Company (Check the appropriate ONE.)
Metropolitan Life Insurance Company The Company indicated in this section is referred to as "the Insurer".

- 200 Park Avenue, New York, NY 10166
- New England Life Insurance Company 🗌 501 Boylston Street, Boston, MA 02116-3700

MetLife Investors Insurance Company Metropolitan Tower Life Insurance Company 13045 Tesson Ferry Road, St. Louis, MO 63128

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.

General American Life Insurance Company

MetLife Investors USA Insurance Company

222 Delaware Ave., Suite 900, P.O. Box 25130, Wilmington, DE 19899

13045 Tesson Ferry Road, St. Louis, MO 63128

200 Park Avenue, New York, NY 10166

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/antigenpositive 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.

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.

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 Áids 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 Kuna at 322-9705 Maui at 243-5075 Lanai at 565-6411 Molokai at 553-3145 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 AIDS Action Line at	1-800-782-2437 1-800-235-2331
IN RHODE ISLAND:	
Rhode Island Department of Health, Office of AIDS/STD at Rhode Island Project AIDS Hotline at	401-222-2320 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.

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

① 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.

MetLife®

Life Insurance Buyer's Guide

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

Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company

General American Life Insurance Company
MetLife Investors USA Insurance Company

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. This guide does not endorse any company or policy.

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Important Things to Consider

- 1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
- 2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
- 3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
- 4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
- 5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
- 6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
- 7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need and for how long and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you. Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.

- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

Life Insurance Buyer's Guide

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?.
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the new policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced

- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and study it carefully. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Buyer's Guide

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider.

For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies those that offer basically the same benefits, with premiums payable for the same length of time.

One type of index, called the life insurance yield comparison index, is a measure of cash value growth over the index period which takes into account the interest credited, the estimated value of the death protection provided, and the expenses charged. A higher yield index number generally indicates a better buy. Since this index reflects items other than interest earnings, it may differ from the credited interest rate advertised or guaranteed in your policy. For the same reason, the yield index will differ substantially from the return on a pure investment like a savings account. Keep this in mind if you attempt to compare yield indexes with investment returns.

Another type of index, the net payment cost comparison index helps you compare costs over a 10 or 20 year period assuming you will continue to pay premiums on your policy and do not take its cash value. It is useful if your main concern is the benefits that are to be paid at your death.

The most important thing to remember is that, when using the net payment cost comparison index, a policy with smaller index numbers is generally a better buy than a similar policy with larger company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will also be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

index numbers. When using the life insurance yield comparison index, the opposite is true: a policy with larger yield comparison index numbers is generally a better buy than one with smaller yield comparison index numbers.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

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MetLife

Temporary Insurance Agreement and Receipt

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

SECTION I - What Does Temporary Insurance Provide?

For those eligible, Temporary Insurance provides for a death benefit upon receipt of proof of death of the Proposed Insured(s). The Temporary Insurance death benefit will be for the amount of insurance (including riders) applied for on the life of the deceased Proposed Insured(s) named on the application bearing the date of this Receipt and the supplement(s) to that application (collectively the "Application"). The total death benefit under this Receipt and all other receipts issued by all the companies listed above will not be more than \$1,000,000 for any Proposed Insured(s) (\$2,000,000 for survivorship life policies).* However, there will be no death benefit provided for the first death on a survivorship policy, or if death is by suicide. The death benefit will be paid to the person who would have received payment under the policy, had it been issued.

If the health or insurability of the Proposed Insured(s) changes once Temporary Insurance has started, the Company will consider the health of the Proposed Insured(s) as of the date Temporary Insurance began in deciding whether to issue the policy applied for. If the Proposed Insured(s) should have a material change in health or insurability while Temporary Insurance is in effect, the total amount of insurance which may be issued under this Receipt and all other receipts will not be more than \$1,000,000 (\$2,000,000 for survivorship life policies).*

If there is a person to be insured under an applicant waiver of premium rider or benefit (an "Applicant"), this benefit or rider will be included in the policy issued on the life of the Proposed Insured(s) if an Applicant dies: 1. Other than by suicide; 2. Before the rider or benefit is declined by the Company; and 3. While Temporary Insurance is in effect on the life of the Proposed Insured(s).

Premiums under the policy will be waived under the terms of the rider or benefit applied for.

*Should there be more than one application or receipt for any person to be insured, the share for each application will be in the ratio that the amount applied for on that application bears to the total amount of insurance applied for under all such applications.

SECTION II - Who is Eligible for Temporary Insurance?

The Proposed Insured(s) under the policy applied for is/are eligible for Temporary Insurance, if EACH of the following is true:

- 1. The Application, its supplements and paramedical/medical exam; do not include any material misrepresentation. AND
- The Proposed Insured(s) has/have never received medical treatment for or been diagnosed with: cancer; Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); coronary artery disease; stroke; alcohol use; or drug use. AND
- **3.** The Proposed Insured(s) is/are at least 14 days old.

SECTION III - When Does Temporary Insurance Start?

Coverage starts on the later of the date of this Receipt or (if required at the time the Application was completed by the Company's underwriting rules) the date of any medical examination of the Proposed Insured(s) provided that one of the following is satisfied on the date of the Application:

- 1. Payment by check of an amount of at least 1/12 of an annual premium; or
- 2. Payment of Initial Premium Draft per Electronic Funds Transfer; or
- **3.** Properly completed MetLife salary deduction plan form(s); or
- 4. Properly completed government allotment form(s); or
- **5.** If the life insurance applied for with the Application is to be part of a Qualified Plan under the Employee Retirement Income Security Act of 1974 "ERISA" (e.g. a Pension Plan, Profit Sharing Plan, or a 401(k) Plan) and the Proposed Owner is the trustee of the Qualified Plan and the Employer Group Number (EGN) assigned by the Company is entered in the appropriate space on the Application, and a copy of the Commission Disclosure forms is provided to the Proposed Owner.

If a check or draft is returned for insufficient funds it will not constitute payment and Temporary Insurance will not be in effect.

Temporary Insurance will be in effect, if it has not already ended under the terms of this Receipt, if a Proposed Insured dies: from an accident; within 30 days from the date of this Receipt; before the required medical exam described above is completed; and one of the above 5 items was received on the date of the Application.

SECTION IV - When Does Temporary Insurance End?

Temporary Insurance will end on the earliest of the following:

- 1. When coverage under a policy issued by the Company as a result of the Application takes effect.
- 2. When a policy issued by the Company as a result of the Application is not accepted.
- 3. When the Company offers to refund any payment received under this Receipt.
- 4. When the Company refunds any payment received under this Receipt.
- The date the Proposed Insured(s) or an Applicant learns that either the Application has been declined or the Company has decided to 5. terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
- If the Application is for a Qualified Plan under ERISA, the Proposed Owner learns that either the Application has been declined or the 6. Company has decided to terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
- One hundred and twenty (120) days from the date of this Receipt. 7.

If no policy takes effect, any payment received will be refunded when Temporary Insurance ends.

SECTION V - Limitations on Authority

No one but the President, Vice-President or the Secretary of the Company may change or waive the terms of this Receipt.

Signatures

All Premium Checks must be made payable to the Company checked on top of page 1. DO NOT MAKE CHECK PAYABLE TO THE AGENT. DO NOT LEAVE THE CHECK PAYEE BLANK. Method of Collection: Amount Collected Check (Must be at least 1/12 of an annual premium.) Initial Premium by Debit Authorization in application (Must be at least a monthly amount.) ☐ Initial Premium by EP Account Agreement form (Must be at least a monthly amount.) MetLife Salary Deduction Plan form(s) Or receipt of: Government Allotment form(s) Qualified Plan form(s) is acknowledged in connection with the Application made on this date in which the Proposed Insured(s) is/are: and the plan of insurance is: ______ from ______ Receipt Date: Title: Sales Office: Producer Signature: Signed at City, State Date Metropolitan Life Insurance Company New England Life Insurance Company General American Life Insurance Company St. Louis, MO 63128 New York, NY 10166 Boston, MA 02116 Aven L. Carr Nam Dord-Ham Dord-Gwenn L. Carr, Senior Vice-President and Secretary Daniel D. Jordan, Vice-President and Secretary Daniel D. Jordan, Vice-President and Secretary MetLife Investors USA Insurance Company MetLife Investors Insurance Company Wilmington, DE 19899 St. Louis, MO 63128 Richard c Pearson Richard C Pearson

Richard C. Pearson, Executive Vice-President

Richard C. Pearson, Executive Vice-President

Note: If you have not heard from the Company within 120 days from the date of this Receipt, please contact the Company's representative.



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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).

Acceleration of Death Benefit Rider (ADBR) Summary and Disclosure Statement

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

General American Life Insurance Company MetLife Investors USA Insurance Company

This Summary and Disclosure Statement gives a brief description of the important features of the Rider. This is not an insurance contract and only the actual provisions of the Rider will control. The Rider itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, very important that you READ THE RIDER CAREFULLY.

TAX CONSEQUENCES

In general, the receipt of benefits under the Rider is not subject to Federal income tax. You should consult a personal tax advisor to see how benefits will be treated based on your specific facts and circumstances.

AVAILABILITY

An Accelerated Death Benefit is available if the Insured is terminally ill, subject to the terms of the Rider. The Rider provides for the partial or full acceleration of the Eligible Proceeds of the Policy.

ELIGIBLE PROCEEDS

Eligible Proceeds equal: the Policy proceeds as defined in the Policy; less any face amount provided by a Supplemental Coverage Term Rider; plus any amount of benefit provided by a rider that we consent to apply to an Accelerated Death Benefit. Eligible Proceeds will be calculated as of the date we receive a request for the Accelerated Death Benefit.

AMOUNT OF ACCELERATED DEATH BENEFIT

We will compute the Accelerated Death Benefit based on the following:

- 1. The amount of Eligible Proceeds you choose to accelerate;
- 2. Reduced life expectancy;
- 3. A processing charge not to exceed \$150; and
- 4. An Interest Rate no greater than the greater of: a. The current yield on 90 day treasury bills; and
 - b. The current maximum statutory adjustable policy loan interest rate.

PAYMENT OF AN ACCELERATED DEATH BENEFIT

Unless otherwise requested, we will pay the Accelerated Death Benefit in one sum or by placing the amount in an account that earns interest. The Owner will have immediate access to all or any part of the account.

EFFECT OF ACCELERATION

If **part** of the Eligible Proceeds are applied to the Accelerated Death Benefit, any policy values and the death benefit on the remaining policy will be reduced proportionately. We will provide full disclosure of the effects of the acceleration on the policy's cash value if any, death benefit, premiums, policy loans if available and face amount.

If **all** of the Eligible Proceeds are applied to the Accelerated Death Benefit, all policy benefits based on the Insured's life, except for any benefit for accidental death, will end. Any accidental death benefit will continue in force under the conditions stated in the Rider. Any riders that provide a benefit on the life of someone other than the Insured will stay in effect pursuant to their terms as if the Insured had died. No further cost for those riders will be payable.

SAMPLE ILLUSTRATION

The chart below is a generic example of how an accelerated payment might affect a policy. Your results will be different. The Owner has requested an acceleration payment equal to half of the Eligible Proceeds, or \$97,500. This amount was calculated by subtracting the outstanding loan from the face amount of the Policy and taking half of that amount.

Accelerated Death Benefit would be calculated as follows: amount of Eligible Proceeds requested to accelerate, less actuarial discount for interest and reduced life expectancy and less the processing charge.

\$ 97,500- **\$**5,301- **\$**150 = **\$** 92,049.

	Before	After
Face Amount:	\$200,000	\$100,000
Cash Value:	\$8,000	\$4,000
Outstanding Policy Loan:	\$5,000	\$2,500
Annual Premium:	\$1,050	\$525

COST

There is no additional premium charged to add this Rider to a policy. There will be a processing charge when an accelerated death benefit payment is made not to exceed \$150.

GOVERNMENT ENTITLEMENTS

RECEIPT OF AN ACCELERATED BENEFIT MAY ADVERSELY AFFECT THE RECIPIENT'S ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SECURITY INCOME ("SSI") OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. Therefore, prior to exercising the acceleration, you should contact the appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office).

ACCELERATION

The acceleration can be processed if the Insured has a medical condition that is expected to result in death within 12 months. To make a claim, provide us with a statement signed by a physician that the Insured has a medical condition that is expected to result in death within 12 months. The physician may not be the Owner, the Insured, or a member of the Insured's family. We have the right to have the Insured examined at our expense by a physician we choose. This right will be exercised at places convenient to the Insured. The Rider outlines other conditions for acceleration.

LIMITS OF THE ACCELERATION OF DEATH BENEFIT RIDER

THE RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT DESIGNED TO ELIMINATE THE NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated death benefit payment. An accelerated death benefit payment may not be enough to cover your medical or other bills.

OTHER OPTIONS

Even though it is attached to the Policy, the Rider does not have to be exercised. The Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. Alternatively, if provided for by your Policy, you may elect to receive a loan, a partial withdrawal or to make a surrender.

TERMINATION OF ACCELERATED DEATH BENEFIT

The Rider will terminate at the earliest of:

- 1. When an Accelerated Death Benefit is paid;
- 2. When the Policy to which this Rider is attached terminates; and
- 3. The monthly anniversary on or following receipt by us at our Home Office or any other office designated by us of your written request to terminate this Rider. We may require the Policy for endorsement.

The Rider will not take effect if its attachment to the Policy could cause the Policy to be disqualified as life insurance under the Internal Revenue Code.



Replacement Package for Life Insurance

Forms to be submitted if the application involves a replacement.

Table of Contents and Instructions -

Form Name	Form Number	Instructions/Notes
Replacement Questionnaire	EREPL	To be completed when canceling or altering an existing policy or contract in conjunction with an application for a new policy or contract. Signatures Required
1035 Exchange Authorization	E1035EXCH	Authorization for a Life to Life 1035 Exchange. Note: A separate form must be completed for each existing financial institution. Signatures Required
Notice Regarding Replacement of Life Insurance or Annuity	EREPLDIS-CA-A	Signatures Required
Supplement to the California "Notice Regarding Replacement" Form	EREPLDIS-CA-B	Use this form for same Company Replacement Only Signatures Required

Policy Number _____

Replacement Questionnaire

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

SECTION I - Funding of New Policy

How is the **NEW** policy to be funded? (Please check all that apply.)

SECTION II - Canceling or Altering an Existing Policy or Contract

□ From Existing Policy or Annuity

🗌 Fu	ll cash	surrender
------	---------	-----------

Loan

Partial cash surrender or withdrawal

Redirection of premium(s)/remittance(s)Reduction in coverage

Out of pocket premium payments

ts 🗌 Other - Please explain: _____

□ Dividends

Company	Plan Type*	Policy Number	lssue Date	Face Amount (Only)	Future Premium Payment Status**	Amo	mium unt and ency***	Cash Value	Surrender Charge	Check if 1035
Will the transactio					ease provide p	policy n	umber fro	m above		
*Policy Plan Type: PERM - Any Permanent Life which is not Universal Life or Variable Life ENDW - Endowment TERM - Term						versal L iable Lit ed Annu	fe	IANN - Index VUNI - Varia VANN - Varia	ble Univers	al Life
 ** Future Premium Payment Status: A - Pay limited number of premiums out of pocket, then use values in the policy B - Existing or future policy values and/or value of future dividends C - The out-of-pocket premiums will be suspended or reduced. NOTE: Please provide a copy of the illustration. D - Premium payments will be discontinued. Policy will operate under its nonpayment of premiums option. E - Continue to pay premiums out of pocket 					I.					
F - Surrender or Cancel G- Other – Please explain										
***Frequency cod Signatures	***Frequency codes: A=Annual S=Semiannual Q=Quarterly M=Monthly									

The proposed coverage is appropriate for my financial objectives for the following reasons:

Owner's Signature	Date		
the owner.		he owner. Any state required documentation	·
Check box - In three jurisdictions	- CT, DC, ND) - I have prov	ided the Company Replacement disclosure	form.
Producer Signature	Date	Management Signature	Date

1 of 1

MetLife

Policy Number

Authorization for Life to Life: 1035 Exchange

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

Complete a separate form for each existing insurer.

General American Life Insurance Company

MetLife Investors USA	Insurance Company
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SECTION I - Policy and Loan Carry-over Election

Policy Number Carry over existing loan? Yes No		Policy Number	Carry over existing loan?
	🗌 Yes 🔲 No		🗌 Yes 🗌 No
	🗌 Yes 🗌 No		🗌 Yes 🔲 No

The policy numbers listed above will be referred to as "Policy."

SECTION II - Exchange and Assignment Agreement

The undersigned assigns all right, title and interest in the Policy issued by

("Insurer") on the life of

("Insured") to the Company. If, for any reason, I receive a check for the cash surrender value of this Policy, I irrevocably agree and obligate myself to endorse such check over to the Company pursuant to this assignment.

This assignment is made to exchange the Policy for a life insurance policy issued by the Company pursuant to section 1035 of the Internal Revenue Code. It is understood that the Company intends to surrender the Policy for its cash value. Any existing loan will be carried over to the new policy if: 1) requested in Section I above, 2) available with the new policy, and 3) accepted by the Insurer. If the loan is carried over, the Company will apply the gross cash value as a premium for a new life insurance policy issued on the Insured named above.

It is also understood that the Company will withdraw its request for surrender of the policy if the Insurer advises that 1) the Policy is an endowment or annuity and/or 2) the Insurer advises that the surrender of the Policy would result in taxable income.

The effective date of this assignment shall be the date that the Company approves a policy on the life of the Insured.

Acceptance by the Company of this assignment and of policy values from the Insurer should not be construed as a guarantee that the transaction will qualify as a 1035 exchange. The undersigned agrees that the Company has no responsibility for the undersigned's tax treatment under section 1035 of the Internal Revenue Code or otherwise.

I UNDERSTAND THAT NEITHER THE COMPANY NOR ITS **REPRESENTATIVES CAN GIVE ME TAX OR LEGAL ADVICE.** AND I ASSUME FULL RESPONSIBILITY FOR THE TAX EFFECTS **OF THIS TRANSACTION.**

I have enclosed the existing Policy with this form. If the Policy is not enclosed, I certify that it has been lost or destroyed.

SECTION III - Signatures

• Owner's Signature		Date	
SSN/TIN	Signed at		
As witness, I attest to	having observed the Owner sign in my	presence.	
Witness Signature			
Joint Owner's Signatu	re	Date	
SSN/TIN			
As witness, I attest to	having observed the Joint Owner sign	in my presence.	
Witness Signature			
Irrevocable Beneficiary	y's Signature	Date	
	Signed at		
As witness, I attest to	having observed the Irrevocable Benef	iciary sign in my presence.	
Witness Signature			
			1

SECTION IV - Current Insurer Information

ATTN Policyowner Service Department Current Insurer's Name

Address

SECTION V - Cash Surrender and Loan Carryover Request						
▲ For MetLife and affiliate use only - To be completed by Home Office						
Name has requested that each Policy listed below be exchanged for a new life insurance						
policy. In order to implement this request, the Company hereby requests the cash surrender of each Policy listed below.						
Policy Numbers						
The undersigned confirms that the Company 🛛 will 🗌 will not accept the carryover of any existing loan to the new policy.						
Notwithstanding the foregoing: Do not surrender the policy if it is an endowment or annuity. Do not surrender the policy if there is an existing policy loan which would result in taxable income or if there is any other reason that would cause you to report income.						
For each policy, please advise: ■ cash surrender value ■ any outstanding loan amount ■ cost basis information ■ taxable income ■ whether Policy is a Modified Endowment Contract.						
Make the check payable to the Company listed below and please indicate on all checks the Policyowner's name and MetLife Policy No						
Please send the check and the requested information to:						
MetLife 1035 Exchange Lockbox 13530 Collections Center Drive Chicago, IL 60693						
Please do no withholding. The Company's Taxpayer Identification Number is:						
Special Instructions:						
Company Name						
By (Name) Title						
Date						

2 of 2

Notice Regarding Replacement of Life Insurance or Annuity

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

Company Copy

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one?

If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the agent or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

*or application or receipt number

Signatures

►	Applicant's Signature	Date
►	Agent's Signature	Date



1%1%2%07%4%10086%7%1%14%Y

Notice Regarding Replacement of Life Insurance or Annuity

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

Applicant Copy

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

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Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

*or application or receipt number

Signatures

►	Applicant's Signature	Date
►	Agent's Signature	Date

1 of **1**

Supplement to the Ca	alifornia	a "Notice Re	egarding F	Replace	ment" Form	Company Copy	
Company (Check the appropriate ONE.) The Company indicated in this section is referred to as " the Company ".		Metropolitan Life Insurance Company General American				can Life Insurance Company ors USA Insurance Company	
		USE ONLY FOR	R SAME COM	PANY REP	LACEMENT		
Name of Proposed Insured First	Middle	Last	Existing Po	licy #		Policy Information as of (Date)	
GENERAL INFORMATION Basic Policy Type/Insured Rider 1: Type/Insured Rider 2: Type/Insured Rider 3: Type/Insured Rider 4: Type/Insured Issue Age Issue Date Contestability Period Expires Suicide Clause Expires		ng Life Insurar	nce/Annuity	Proposed	Life Insurance	Proposed Annuity	
PREMIUM DATA/ DEATH BENEFITS Basic Policy Premium (1) Annual Target Premium Rider 1 Premium Rider 2 Premium Rider 3 Premium Rider 4 Premium Total Premium		ng Life Insurar liately Before	nce/Annuity Immediately	y After	Proposed Life Insura	nce Proposed Annuity	
Basic Policy Death Benefit (2) Div. Adds. Death Benefit (AI) Rider 1 Death Benefit Rider 2 Death Benefit Rider 3 Death Benefit Rider 4 Death Benefit							
CASH VALUES/DIVIDENDS Guaranteed Cash Value (Trad.) Accumulation Fund (UL/ULII/Annuities) Accumulated Dividends (DWI) Cash Value of Div. Adds. (AI) PUAR Cash Value Policy Loan Loan Interest Rate % Additional Comments		ng Life Insuran liately Before	nce/Annuity Immediatel	y After	Proposed Life Insura	nce Proposed Annuity	

Notes: If your policy is not issued as applied for, another form will be provided.

1. For universal life policies indicate the total amount being paid annually.

2. Basic Policy Death Benefit represents the face value of your life insurance policy. The actual death benefit payable may be increased by dividends with interest (DWI) and decreased by any outstanding indebtedness, plus accrued loan interest, on the policy.

Applicant's Signature

Agent's Signature

1%1%2%07%4%10086%7%1%14%Y

1 of 1

Supplement to the Ca	alifornia	"Notice R	egarding l	Replace	ement" Form	Applicant Copy
				erican Life Insurance Company estors USA Insurance Company		
	ι	JSE ONLY FO	R SAME COM	PANY RE	PLACEMENT	
Name of Proposed Insured First	Middle	Last	Existing Pc	olicy #		Policy Information as of (Date)
GENERAL INFORMATION Basic Policy Type/Insured Rider 1: Type/Insured Rider 2: Type/Insured Rider 3: Type/Insured Rider 4: Type/Insured Issue Age Issue Date Contestability Period Expires Suicide Clause Expires	Existing	g Life Insura	nce/Annuity	Proposed	d Life Insurance	Proposed Annuity
PREMIUM DATA/ DEATH BENEFITS Basic Policy Premium (1) Annual Target Premium Rider 1 Premium Rider 2 Premium Rider 3 Premium Rider 4 Premium Total Premium		g Life Insuran ately Before	nce/Annuity Immediatel	y After	Proposed Life Insur	ance Proposed Annuity
Basic Policy Death Benefit (2) Div. Adds. Death Benefit (Al) Rider 1 Death Benefit Rider 2 Death Benefit Rider 3 Death Benefit Rider 4 Death Benefit						
CASH VALUES/DIVIDENDS Guaranteed Cash Value (Trad.) Accumulation Fund (UL/ULII/Annuities) Accumulated Dividends (DWI) Cash Value of Div. Adds. (AI) PUAR Cash Value Policy Loan Loan Interest Rate %		g Life Insurar ately Before	nce/Annuity Immediatel	y After	Proposed Life Insul	rance Proposed Annuity
Additional Comments						

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