For use in the State of:
California

MetLife®

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.

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

 - For Your Information

 - Refer to Supplement

 - Attention

MetLife®

Policy Number _____

Application for Life Insurance

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

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

SECTION I - About the Proposed Insured

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

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

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

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

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

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

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

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

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

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

SECTION II - About the Owner

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

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

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

☐ **OWNER - OTHER INDIVIDUAL**

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

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

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

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

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

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

SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries, use Section IX - Additional Information.

☐ Check here if the Owner is the Primary Beneficiary.

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

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

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

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

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

SECTION IV - About Proposed Coverage

Check the desired coverage(s).

☐ Universal Life | ☐ Variable Life

Product Name

Face Amount*

Riders and Details

☐ Coverage Continuation (UL only)

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

Death Benefit Option _____

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

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

☐ Whole Life

Product Name

Face Amount*

Riders and Details

☐ Disability Waiver

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

☐ Automatic Premium Loan Requested

☐ Term Life

Product Name

Face Amount*

Riders and Details

Disability Waiver:
☐ Convertible ☐ Non-Convertible

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

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

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

ADDITIONAL OPTIONS

One Time (Single) Payment Amount _____ 1035 Exchange Amount _____ Requested Policy Date _____ ☐ Save Age

POLICY OPTIONS

☐ Alternate Policy: Product, Face Amount and Details _____

☐ Additional Policy: Product, Face Amount and Details _____

☐ Group Conversion Only
☐ Group Conversion Alternative

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

SECTION V - About Existing or Applied for Insurance

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

Proposed Insured ☐ Yes ☐ No
Owner ☐ Yes ☐ No

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

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

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

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

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

☐ Spouse ☐ Child ☐ Parent ☐ Other _____

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

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

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

SECTION VI - About Payment Information

PREMIUM PAYOR

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

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

Reason this Person is the Payor _____

Permanent Address _____ City _____ State _____ Zip _____

PAYMENT MODE
(Check the appropriate ONE.)

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

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

INITIAL PAYMENT

Amount Collected with Application _____

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

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

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

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

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

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

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

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

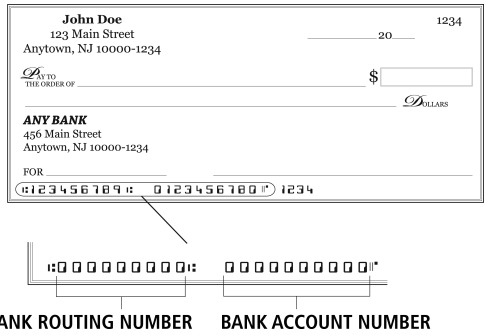
Monthly Debit Date: ☐ Issue Date of the Policy

☐ Debit Date on the _____ of each month

Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number _____ Bank Account Number _____

Name of Financial Institution _____



BANK ROUTING NUMBER BANK ACCOUNT NUMBER

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

We cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services from foreign banks UNLESS the check is being paid in U.S. Dollars through a U.S. correspondent bank (the U.S. correspondent bank name must be on the check).

SECTION VII - General Risk Questions

Use Section IX - Additional Information if necessary.

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

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

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

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

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

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

If **YES,** please provide details.

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

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

Product(s)	Frequency / Amount	Date Last Used

5. 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? ☐ Yes ☐ No
If **YES,** list type of felony, state, and date of occurrence.

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

SECTION VIII - Personal Physician

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

Physician Name

Name of Practice or Clinic

Street Address

City

State

Zip

Phone Number

Date Last Consulted

Reason

Findings/Treatment Given/Medication Prescribed

SECTION IX - Additional Information

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

Certification / Agreement / Disclosure

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

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

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

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

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

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

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

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

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

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

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

Agreement / Disclosure

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

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

Taxpayer Identification Number Certification

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

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

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

Signatures

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

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

▶ _____ _____ _____

▶ _____ _____ _____

(age 18 or over)

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

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

▶ _____ _____ _____

▶ _____ _____ _____

(age 18 or over)

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

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

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

▶ _____ _____ _____

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

Witness to Signatures

Licensed Producer | Print Name of Producer

▶ _____ _____

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:

- 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.**

Signatures

Print Name of Proposed Insured — Date of Birth

First _____ Middle _____ Last _____ _____

If Proposed Insured is under 18, the ☐ **Parent** or ☐ **Guardian** is to sign on line for such child.

Signature of Proposed Insured — Date — Signed at City, State

▶ _____ _____ _____

As witness, I attest to having observed all parties sign in my presence.
Witness to Signature

▶ _____

MetLife®

Proposed Insured: _____ _____ _____

First Name Middle Name Last Name

Notice and Consent For HIV-Related Testing

Company Copy

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

- ☐ Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166
- ☐ General American Life Insurance Company, 13045 Tesson Ferry Road, St. Louis, MO 63128
- ☐ New England Life Insurance Company, 501 Boylston Street, Boston, MA 02116-3700
- ☐ MetLife Investors USA Insurance Company, 222 Delaware Ave., Suite 900, P.O. Box 25130, Wilmington, DE 19899
- ☐ MetLife Investors Insurance Company, 13045 Tesson Ferry Road, St. Louis, MO 63128
- ☐ Metropolitan Tower Life Insurance Company, 200 Park 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:

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

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

MEANING OF POSITIVE HIV TEST RESULT

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

SIDE EFFECTS

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

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.

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Name of Proposed Insured (Please Print)

First _____ Middle _____ Last _____

Signature of Proposed Insured or Parent/Guardian

▶ _____

Date

_____

Witness

_____

Producer Identification & Certification

⚠ **Incomplete information may delay your application.**

1. What is the purpose of insurance? (Check **ALL** that apply.)

☐ Estate Planning ☐ Charitable Giving ☐ Qualified Plan ☐ Mortgage Protection ☐ Buy/Sell
☐ Executive Bonus ☐ Split Dollar ☐ Private Split Dollar ☐ Deferred Compensation ☐ Key Person
☐ Business Needs - Other ☐ Income Protection ☐ Other _____

2. Method used to arrive at the Face Amount Recommendation?

☐ Profiles Needs Analysis ☐ Human Life Value ☐ GSIB Proposal ☐ Other _____

3. Was this sale made using an illustration with Accelerated Premium? If **YES,** please indicate number of years. ☐ Yes ____yrs. ☐ No

4. Is this insurance a replacement? ☐ Yes ☐ No

5. Have you completed and attached the required replacement forms? ☐ Yes ☐ No ☐ N/A

6. Have you attached the Internal Revenue Code Section 1035 form? ☐ Yes ☐ No ☐ N/A

7. Have the following documents been delivered:

Privacy Notice	☐ Yes	☐ No		Life Insurance Buyer's Guide	☐ Yes	☐ No	
HIV Notice and Consent Form	☐ Yes	☐ No	☐ N/A	Temporary Insurance Agreement and Receipt	☐ Yes	☐ No	☐ N/A
Compensation Disclosure Notice*	☐ Yes	☐ No	☐ N/A	Military Disclosure	☐ Yes	☐ No	☐ N/A
Debit Authorization Disclosure	☐ Yes	☐ No	☐ N/A	Current prospectus for variable products and riders	☐ Yes	☐ No	☐ N/A
ABR/ADBR Disclosure Statement	☐ Yes	☐ No	☐ N/A				

*Only required for business sold by Agency Distribution Group (MetLife and NEF), MLR and MetLife Auto & Home sales representatives.

8. Did you use only sales material approved for use by the appropriate Company? ☐ Yes ☐ No

9. Did you see all persons to be insured on the date the application was taken? ☐ Yes ☐ No If **NO,** why not? _____

10. Do any of the Beneficiaries (Primary or Contingent) or their dependents have special needs? ☐ Yes ☐ No

11. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No If **YES,** indicate relationship _____

12. Are the Proposed Insured(s) and Owner(s) interested in electronic delivery of product reports? ☐ Yes ☐ No

Certification of Owner Identity:

☐ I certify that I personally met with the Owner(s)/legal representative(s) of the entity and reviewed the appropriate identification documents. To the best of my knowledge the documents accurately reflect the identity of the Owner(s)/legal representatives of the entity.

☐ 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	Commission Split % 1st Year	Commission Split % Renewal	Amount of GDC (for MLD only)

Signatures

Name of Producer _____ ▶ Producer Signature _____ Date _____

I have personally reviewed this application for appropriateness of sale. The Producer was appropriately licensed and appointed on the date 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 Producers 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 _____

MetLife®

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
- ☐ 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 - Income

Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned $ _____

Source _____

Total Unearned Income $ _____

Additional Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned $ _____

Source _____

Total Unearned Income $ _____

SECTION II - Assets and Liabilities

Proposed Insured

Assets (in US dollars)

Cash $ _____

Real Estate $ _____

Business Equity $ _____

Stocks/Bonds $ _____

Other Assets $ _____

Total Assets $ _____

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth $ _____

(Total Assets - Total Liabilities)

Additional Proposed Insured

Assets (in US dollars)

Cash $ _____

Real Estate $ _____

Business Equity $ _____

Stocks/Bonds $ _____

Other Assets $ _____

Total Assets $ _____

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth $ _____

(Total Assets - Total Liabilities)

MetLife®

Policy Number _____

Medical Supplement

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

This supplement will be attached to and become part of the application with which it is used.

SECTION I - Medical Questions

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

ⓘ If FULL PARAMEDICAL/MEDICAL EXAM is required, completion of this Medical Supplement form is **OPTIONAL.**

Proposed Insured - First Name _____ Middle Name _____ Last Name _____

1. Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____

Has the Proposed Insured experienced a change in weight greater than 10 pounds 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 years, been diagnosed, received treatment, or consulted with a health professional for any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ High Blood Pressure
B. ☐ Chest Pain
C. ☐ Heart Attack
D. ☐ Heart Murmur
E. ☐ Diabetes
F. ☐ High Cholesterol
G. ☐ Cancer / Tumor / Polyp
H. ☐ Asthma / Bronchitis
I. ☐ Emphysema
J. ☐ Sleep Apnea
K. ☐ Seizures
L. ☐ Stroke / TIA
M. ☐ Paralysis
N. ☐ Multiple Sclerosis
O. ☐ Parkinson's Disease
P. ☐ Alzheimer's Disease
Q. ☐ Memory Loss
R. ☐ Colitis
S. ☐ Cirrhosis
T. ☐ Hepatitis
U. ☐ Arthritis
V. ☐ Lupus
W. ☐ Anemia
X. ☐ Depression / Anxiety
Y. ☐ Eating Disorder

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

3. Other than as indicated above, has the Proposed Insured, within the last 10 years, had any disease or disorder of any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ Heart
B. ☐ Arteries / Veins
C. ☐ Lungs / Respiratory System
D. ☐ Gastrointestinal / Digestive System
E. ☐ Liver / Pancreas
F. ☐ Kidney / Bladder
G. ☐ Prostate
H. ☐ Reproductive Organs
I. ☐ Brain / Nervous System
J. ☐ Blood
K. ☐ Lymph Nodes
L. ☐ Immune System
M. ☐ Thyroid / Other Glands
N. ☐ Eyes
O. ☐ Ears / Nose / Throat
P. ☐ Skin
Q. ☐ Muscles / Bones / Joints
R. ☐ Emotional / Psychological Disorder

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

4. Other 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. 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. 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. 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			

MetLife®

Proposed Insured: _____ _____ _____
First Name | Middle Name | Last Name

Notice And Consent For HIV-Related Testing

Company Copy

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

- ☐ Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166
- ☐ New England Life Insurance Company, 501 Boylston Street, Boston, MA 02116-3700
- ☐ MetLife Investors Insurance Company, 13045 Tesson Ferry Road, St. Louis, MO 63128
- ☐ General American Life Insurance Company, 13045 Tesson Ferry Road, St. Louis, MO 63128
- ☐ MetLife Investors USA Insurance Company, 222 Delaware Ave., Suite 900, P.O. Box 25130, Wilmington, DE 19899
- ☐ Metropolitan Tower Life Insurance Company, 200 Park 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:

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

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

MEANING OF POSITIVE HIV TEST RESULT

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

SIDE EFFECTS

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

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.

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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.

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Name of Proposed Insured (Please Print)

First _____ Middle _____ Last _____

Signature of Proposed Insured or Parent/Guardian

▶ _____

Date

_____

Witness

_____

MetLife®

Notice And Consent For HIV-Related Testing

Proposed Insured Copy

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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.

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

IN CALIFORNIA:

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

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

IN HAWAII:

Hilo at 933-4678
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	1-800-782-2437
AIDS Action Line at	1-800-235-2331

IN RHODE ISLAND:

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

IN VIRGINIA:

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

IN WASHINGTON:

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

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

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

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:

- 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.**

Signatures

Print Name of Proposed Insured — Date of Birth

First _____ Middle _____ Last _____ _____

If Proposed Insured is under 18, the ☐ **Parent** or ☐ **Guardian** is to sign on line for such child.

Signature of Proposed Insured — Date — Signed at City, State

▶ _____ _____ _____

As witness, I attest to having observed all parties sign in my presence.

Witness to Signature

▶ _____

For use in the State of:
California

MetLife®

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**

MetLife®

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.)**

- ☐ From Existing Policy or Annuity
  - ☐ Full cash surrender
  - ☐ Partial cash surrender or withdrawal
  - ☐ Redirection of premium(s)/remittance(s)
  - ☐ Loan
  - ☐ Dividends
  - ☐ Reduction in coverage
- ☐ Out of pocket premium payments
- ☐ Other - Please explain: _____

SECTION II - Canceling or Altering an Existing Policy or Contract

Company	Plan Type*	Policy Number	Issue Date	Face Amount (Only)	Future Premium Payment Status**	Premium Amount and Frequency***		Cash Value	Surrender Charge	Check if 1035
										☐
										☐
										☐
										☐

Will the transaction result in taxable income? ☐ Yes ☐ No If so, please provide policy number from above _____

*Policy Plan Type:

- PERM - Any Permanent Life which is not Universal Life or Variable Life
- ENDW - Endowment
- TERM - Term
- UNIV - Universal Life
- VARI - Variable Life
- FANN - Fixed Annuity
- IANN - Indexed Annuity
- VUNI - Variable Universal Life
- VANN - Variable Annuity

** 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
- F - Surrender or Cancel
- G- Other – Please explain _____

***Frequency codes: A=Annual S=Semiannual Q=Quarterly M=Monthly

Signatures

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

Owner's Signature ▶ _____ Date _____

I agree that this proposed replacement is in the best interest of the owner. Any state required documentation has been provided to the owner.

☐ (Check box - In three jurisdictions - CT, DC, ND) - I have provided the Company Replacement disclosure form.

Producer Signature ▶ _____ Date _____ Management Signature _____ Date _____

MetLife®

Policy Number _____

Authorization for Life to Life: 1035 Exchange

Complete a separate form for each existing insurer.

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 - Policy and Loan Carry-over Election

Policy Number	Carry over existing loan?	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

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

▶ *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 Signature* _____ *Date* _____

SSN/TIN _____ *Signed at* _____

As witness, I attest to having observed the Joint Owner sign in my presence.

▶ *Witness Signature* _____

▶ *Irrevocable Beneficiary's Signature* _____ *Date* _____

SSN/TIN _____ *Signed at* _____

As witness, I attest to having observed the Irrevocable Beneficiary sign in my presence.

▶ *Witness Signature* _____

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:
1. Do not surrender the policy if it is an endowment or annuity.
2. 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

_____

MetLife®

Notice Regarding Replacement of Life Insurance or Annuity

Company Copy

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

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

MetLife®

Notice Regarding Replacement of Life Insurance or Annuity

Applicant Copy

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

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 _____

MetLife®

Supplement to the California "Notice Regarding Replacement" Form

Company Copy

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

USE ONLY FOR SAME COMPANY REPLACEMENT

Name of Proposed Insured: First _____ Middle _____ Last _____

Existing Policy # _____

Policy Information as of (Date) _____

GENERAL INFORMATION	**Existing Life Insurance/Annuity**	Proposed Life Insurance	Proposed Annuity
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			

PREMIUM DATA/ DEATH BENEFITS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Basic Policy Premium (1)				
Annual Target Premium				
Rider 1 Premium				
Rider 2 Premium				
Rider 3 Premium				
Rider 4 Premium				
Total Premium				
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	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
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 _____

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 ▶ _____

MetLife®

Supplement to the California "Notice Regarding Replacement" Form

Applicant Copy

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

USE ONLY FOR SAME COMPANY REPLACEMENT

Name of Proposed Insured: First _____ Middle _____ Last _____

Existing Policy # _____

Policy Information as of (Date) _____

GENERAL INFORMATION	**Existing Life Insurance/Annuity**	Proposed Life Insurance	Proposed Annuity
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			

PREMIUM DATA/ DEATH BENEFITS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Basic Policy Premium (1)				
Annual Target Premium				
Rider 1 Premium				
Rider 2 Premium				
Rider 3 Premium				
Rider 4 Premium				
Total Premium				
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	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
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 _____

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 ▶ _____

MetLife®

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
- ☐ 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 - Income

Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned $ _____

Source _____

Total Unearned Income $ _____

Additional Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned $ _____

Source _____

Total Unearned Income $ _____

SECTION II - Assets and Liabilities

Proposed Insured

Assets (in US dollars)

Cash $ _____

Real Estate $ _____

Business Equity $ _____

Stocks/Bonds $ _____

Other Assets $ _____

Total Assets $ _____

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth $ _____

(Total Assets - Total Liabilities)

Additional Proposed Insured

Assets (in US dollars)

Cash $ _____

Real Estate $ _____

Business Equity $ _____

Stocks/Bonds $ _____

Other Assets $ _____

Total Assets $ _____

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth $ _____

(Total Assets - Total Liabilities)

MetLife®

Policy Number _____

Avocation Risk Supplement

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 supplement will be attached to and become part of the application with which it is used.

Proposed Insured - First Name _____ Middle Name _____ Last Name _____

SECTION I - Underwater Diving

A. Have you engaged in or do you intend to engage in: ☐ Night Diving ☐ Free/Breath Hold Diving ☐ Ice Diving ☐ Treasure Diving ☐ Cave Diving ☐ Rescue/Recovery ☐ Diving Alone ☐ Instruction ☐ Exploration of Sunken Wrecks ☐ Other _____

Date of last participation in any of the above activities _____

B. Average depth achieved: ____ ft. Maximum depth achieved: ____ ft. How often have you achieved this maximum depth? _____

C. Estimate the number of dives: Last 12 months _____ Next 12 months _____

D. Indicate type of equipment used and certifications. _____

SECTION II - Aerial Sports

A. Type: ☐ Skydiving ☐ Hang Gliding ☐ Parachuting ☐ Ballooning ☐ Other _____

B. Estimate the number of dives, jumps, flights: Last 12 months _____ Next 12 months _____

C. Average height: _____ ft. Maximum height of: _____ ft. Maximum duration: _____ min/hrs

D. Type of equipment: ☐ Assembled from a Factory Kit ☐ Homemade ☐ For Experimental Use ☐ Purchased Completely Assembled

E. Provide details of any stunt or exhibition jumps: _____

F. Status: ☐ Professional ☐ Amateur ☐ Name of Affiliated Association _____

SECTION III - Motor Sports

A. Indicate Type:

Motorcycle: ☐ Drag ☐ Scramble ☐ Hill Climbing

Automobile: ☐ Midget ☐ Go-kart ☐ Sports Car ☐ Stock ☐ Modified ☐ Drag

Motorboat: ☐ Modified ☐ Unmodified ☐ Experimental ☐ Jet ☐ Unlimited Hydroplane ☐ Other _____

B. Type of Track: ☐ Dirt ☐ Oval ☐ Closed Circuit ☐ Hill Climb ☐ Paved ☐ Drag Strip ☐ Other _____

C. Vehicle Data: Make & Model: _____ Displacement _____ Average Speed (MPH): ____ Maximum Speed (MPH): _____

D. Number of races for each method and frequency:

Vehicle versus Vehicle: Within the last three years _____ Next 12 months _____

Vehicle versus Clock: Within the last three years _____ Next 12 months _____

E. Status: ☐ Professional ☐ Amateur ☐ Name of Affiliated Association _____

SECTION IV - Other Activities

⚠ Complete if participating in other activity(ies) not listed above.

A. Specify Sport/Activity: _____

B. Give exact location where each activity takes place: _____

C. Describe safety equipment used: _____

D. Club affiliation: Amateur or Professional: _____

E. Frequency of Participation: Last 12 months _____ Next 12 months _____

SECTION V - Additional Details

If necessary, please provide additional details for Sections I - IV.

Section Number and Letter	Details

MetLife®

Policy Number _____

Medical Supplement

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

This supplement will be attached to and become part of the application with which it is used.

SECTION I - Medical Questions

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

ⓘ If FULL PARAMEDICAL/MEDICAL EXAM is required, completion of this Medical Supplement form is **OPTIONAL.**

Proposed Insured - First Name _____ Middle Name _____ Last Name _____

1. Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____

Has the Proposed Insured experienced a change in weight greater than 10 pounds 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 years, been diagnosed, received treatment, or consulted with a health professional for any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ High Blood Pressure
B. ☐ Chest Pain
C. ☐ Heart Attack
D. ☐ Heart Murmur
E. ☐ Diabetes
F. ☐ High Cholesterol
G. ☐ Cancer / Tumor / Polyp
H. ☐ Asthma / Bronchitis
I. ☐ Emphysema
J. ☐ Sleep Apnea
K. ☐ Seizures
L. ☐ Stroke / TIA
M. ☐ Paralysis
N. ☐ Multiple Sclerosis
O. ☐ Parkinson's Disease
P. ☐ Alzheimer's Disease
Q. ☐ Memory Loss
R. ☐ Colitis
S. ☐ Cirrhosis
T. ☐ Hepatitis
U. ☐ Arthritis
V. ☐ Lupus
W. ☐ Anemia
X. ☐ Depression / Anxiety
Y. ☐ Eating Disorder

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

3. Other than as indicated above, has the Proposed Insured, within the last 10 years, had any disease or disorder of any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ Heart
B. ☐ Arteries / Veins
C. ☐ Lungs / Respiratory System
D. ☐ Gastrointestinal / Digestive System
E. ☐ Liver / Pancreas
F. ☐ Kidney / Bladder
G. ☐ Prostate
H. ☐ Reproductive Organs
I. ☐ Brain / Nervous System
J. ☐ Blood
K. ☐ Lymph Nodes
L. ☐ Immune System
M. ☐ Thyroid / Other Glands
N. ☐ Eyes
O. ☐ Ears / Nose / Throat
P. ☐ Skin
Q. ☐ Muscles / Bones / Joints
R. ☐ Emotional / Psychological Disorder

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

4. Other 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. 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. 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. 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			

MetLife®

Policy Number _____

Trust Certification

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 - Purpose of this Form

This form is for use in situations where a Trust is the owner of a life insurance policy issued by one of the MetLife family of companies. The Trustee(s) should complete and execute this form.

ⓘ **NOTE: For Tax Qualified Retirement Plans purchasing Metropolitan Life Insurance Company or Metropolitan Tower Life Insurance Company life insurance, follow the new business procedures for selling life insurance in a Qualified Plan, not this Trust Certification form. NOTE: This Trust Certification form may not be used for a foreign trust.**

SECTION II - General Information

Proposed Insured First Name _____ Middle Initial _____ Last Name _____

Name of Trust _____ State where Created _____ Date Trust was Executed _____ Tax ID Number* _____

* In the case of a living trust, the Tax ID Number may be the same as the grantor's Social Security Number.

SECTION III - Type of Trust

- ☐ Revocable Trust
- ☐ Irrevocable Trust
- ☐ Tax-Qualified Retirement Plan (IRC § 401) (see note above in section 1)
- ☐ Testamentary Trust under the Last Will and Testament of

Name _____

Date of Death _____

Date Will was Executed _____

SECTION IV - Grantor(s)

Name(s) and address(es) of Grantor(s)/Settlor(s)/Plan Sponsor(s) who established the Trust:

Name	Address	City	State	Zip

SECTION V - Beneficiary(ies)

⚠ Do not complete this section if the Trust is a pension trust.

Name(s) and relationship(s) of the beneficiary(ies) of the Trust:

Name	Relationship to Proposed Insured

SECTION VI - Trustee(s)

For multiple trustees only, please print the names of all trustees below and check one of the following boxes: [If a box is not checked, the Company will require all signatures for any request]:

☐ anyone may act alone ☐ all must act unanimously ☐ a majority may act for all ☐ certain trustees must act jointly (print names below)

Trustee _____ Trustee _____ Trustee _____

ⓘ The undersigned Trustee(s) do hereby certify and affirm the following:

1. All information provided on this Certification is accurate and complete.
2. The named trust is currently in effect and has not been revoked, modified or amended in any manner that would cause the representations in this Certification to be incorrect.
3. I/We acknowledge and agree that the Company is relying exclusively on the representations in this Certification and not upon a review of the trust document, even if the trust document has been or is later provided. The Company is permitted to rely upon the representations in this Certification, unless or until notice of any change, amendment, or revocation is provided in writing and delivered to the Company.
4. I/We are duly authorized to act as trustee(s) under the terms of the trust provisions and/or applicable law. I/We have the power to exercise all rights associated with ownership of a life insurance policy, including, but not limited to, purchase, surrender, selection of and transfers between variable funding options, withdrawal of funds, taking a loan or other encumberment and assigning the policy.
5. If licensed to sell life insurance for the MetLife family of companies, the undersigned has reviewed and has abided by the Company's guidelines on producers acting as trustees.
6. Each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company and agrees to hold the Company harmless against all obligations, demands, losses or liabilities (including attorney's fees) that the Company incurred, suffered, or paid or may incur, suffer or pay in the future because of the Company's reliance on this Certification and/or transactions or actions by the undersigned. By indemnifying the Company, each of the undersigned, jointly and severally, individually, and as trustee, indemnifies the Company's agents, officers and employees. This indemnification shall survive termination of this document or the life insurance policy.
7. I/we understand that neither the Company nor its agents are responsible for the estate planning and tax implications of this sale, that they may not give legal or tax advice and that the Company's acceptance of this Certification is not an endorsement of the named trust. I/we have had the opportunity to consult with an independent attorney and/or tax advisor, to the extent necessary, before executing this Certification.
8. **I/We agree to inform the Company in writing of any trust amendments, change of trustee(s), or other facts and events that would affect or alter this Certification.**
9. For life insurance policy/policies being applied for, the Proposed Insured has been informed or is otherwise aware that a policy is being purchased on his/her life.

Signatures

Print Name of Trustee #1 Address

Signature ▶ Date

Print Name of Trustee #2 Address

Signature ▶ Date

Print Name of Trustee #3 Address

Signature ▶ Date

Print Name of Successor Trustee Address

Signature ▶ Date