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.

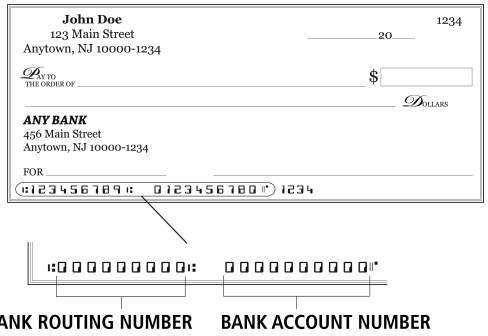
Monthly Debit Date: ☐ Issue Date of the Policy

☐ 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 (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.

1 copy to Company, 1 copy to Proposed Insured

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 _____ Middle _____ Last _____

Signature of Proposed Insured or Parent/Guardian

▶ _____

Date

_____

Witness

_____

1 copy to Company, 1 copy to Proposed Insured

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.

1 copy to Proposed Insured

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			

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. Does the Owner want electronic delivery of the policy and related documents, if available? ☐ 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 Supplement

⚠ **To be completed for all variable life applications, for all applications when the amount of coverage is $1,000,000 and over, and for all applications when the insured is age 55 or 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
- ☐ Metropolitan Tower Life Insurance Company
- ☐ General American Life Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ MetLife Insurance Company of Connecticut

SECTION I - Income

Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars as reported to the IRS)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings (if government assistance, please provide details) $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned Income $ _____

Source _____

Total Unearned Income $ _____

Owner or Premium Payor (if other than Insured)

First Name _____ Last Name _____

Annual Earned Income (in US dollars as reported to the IRS)

Salary or Draw $ _____

Bonus/Commissions $ _____

Other Earnings (if government assistance, please provide details) $ _____

Source _____

Total Earned Income $ _____

Spouse's Income $ _____

Annual Unearned Income (in US dollars)

Dividends/Interest $ _____

Net Rentals $ _____

Other Unearned Income $ _____

Source _____

Total Unearned Income $ _____

SECTION II - Assets, Liabilities, and Expenses

Proposed Insured

Assets (in US dollars)

Cash/Cash Equivalents $ _____

Real Estate $ _____

Business Equity $ _____

Stocks $ _____

Bonds $ _____

Annuities $ _____

Mutual Funds $ _____

CD/Money Markets $ _____

Foreign Assets (Note: if more than 20% of total assets are outside the US, supporting documentation may be requested.) $ _____

Other Assets (Artwork and other personal property must have written appraisals available.) $ _____

Total Assets $ _____

Owner or Premium Payor (if other than Insured)

Assets (in US dollars)

Cash/Cash Equivalents $ _____

Real Estate $ _____

Business Equity $ _____

Stocks $ _____

Bonds $ _____

Annuities $ _____

Mutual Funds $ _____

CD/Money Markets $ _____

Foreign Assets (Note: if more than 20% of total assets are outside the US, supporting documentation may be requested.) $ _____

Other Assets (Artwork and other personal property must have written appraisals available.) $ _____

Total Assets $ _____

Proposed Insured (cont.)

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth (Total Assets minus Total Liabilities) $ _____

Liquid Net Worth:
(The amount of cash (including checking, savings, etc.), and assets that can be turned into cash quickly and easily. Include the amount of the initial premium payment and/or lump sum payment for this coverage. Exclude personal property, personal residence, real estate, business equity, home furnishings, autos and assets subject to substantial penalties/ sales charges.) $ _____

Expenses

Annual Recurring Expenses (e.g., rent, mortgage, long-term debts, utilities, alimony or child support, etc.) $ _____

"Special Expenses" (if any) (e.g., future, non-recurring expenses, such as home purchase/ remodeling, car purchase or repairs, education, medical expenses, etc.) (Blank fields for Special Expenses will be assumed to be $0.) $ _____

Timeframe for Special Expenses (within how many years) (e.g., 1 year for home remodeling, 4 years for education, etc.) _____

Tax Bracket (%) _____

Owner or Premium Payor (if other than Insured) (cont.)

Liabilities (in US dollars)

Mortgages $ _____

Personal Loans $ _____

Other $ _____

Total Liabilities $ _____

Net Worth (Total Assets minus Total Liabilities) $ _____

Liquid Net Worth:
(The amount of cash (including checking, savings, etc.), and assets that can be turned into cash quickly and easily. Include the amount of the initial premium payment and/or lump sum payment for this coverage. Exclude personal property, personal residence, real estate, business equity, home furnishings, autos and assets subject to substantial penalties/ sales charges.) $ _____

Expenses

Annual Recurring Expenses (e.g., rent, mortgage, long-term debts, utilities, alimony or child support, etc.) $ _____

"Special Expenses" (if any) (e.g., future, non-recurring expenses, such as home purchase/ remodeling, car purchase or repairs, education, medical expenses, etc.) (Blank fields for Special Expenses will be assumed to be $0.) $ _____

Timeframe for Special Expenses (within how many years) (e.g., 1 year for home remodeling, 4 years for education, etc.) _____

Tax Bracket (%) _____

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
  - ☐ Loan
  - ☐ Partial cash surrender or withdrawal
  - ☐ Dividends
  - ☐ Redirection of premium(s)/remittance(s)
  - ☐ 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 (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 (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®

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

ⓘ 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 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.

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?
- 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?

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 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 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 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 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 be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

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?

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

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.

MetLife

Electronic Payment (EP) Account Agreement

Instructions: Use this form to establish or change an electronic payment account as a payment method for policies and contracts issued by the companies listed below. Once you have established an EP Account, other products can be included with this account so that payments can be withdrawn on the same date from the same bank account. Please complete this form in its entirety to avoid any delays in processing. If you need assistance completing this form, please call your representative, sales office, or the appropriate number listed under How to Submit this Form.

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 Insurance Company of Connecticut
- ☐ First MetLife Investors Insurance Company
- ☐ MetLife Investors USA Insurance Company
- ☐ MetLife Investors Insurance Company
- ☐ Metropolitan Tower Life Insurance Company

SECTION I - Type of Request

☐ New Authorization (To make regular withdrawals)

☐ Change of Bank Account (Prior Authorization)

☐ Add policy/contract to existing Electronic Payment Account # _____

Note: Individual Disability Income contracts can not be added to existing electronic payment accounts containing any other MetLife products.

SECTION II - Bank Account Owner Information

Primary Owner of the Bank Account: ☐ Individual or ☐ Business Entity

First Name _____ Middle Name _____ Last Name _____

Social Security Number _____

Business Entity _____ Tax ID Number If Company Check _____

Street Address _____

City _____ State _____ Zip _____

Joint Owner of the Bank Account:

First Name _____ Middle Name _____ Last Name _____

Social Security Number _____

SECTION III - Policy/Contract Payment Information

Please complete the following chart using a separate column for each policy/contract.	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____
Recurring Payment Type: Please choose one or more of the following: Premium, Loan, Annuity, PUAR/PAIR, ALBO, ADCW, etc.				
Recurring Payment Amount: Amount to draft every month				
Relationship of Bank Account Owner to Insured or Contract Owner: Please choose one of the following: Self, Spouse/Domestic Partner, Parent, Child, Grandparent, Employer, Guardian, or Contract Owner. (This section is not required for Individual Disability Income Policies) * Please review Bank Draft Disclosure for additional information.				
Initial Premium Advance Payment Amount: *Please review Bank Draft Disclosure for additional information.				

Withdrawal Date is the day of the month we will withdraw from your bank account. If you do not specify a date, monthly withdrawals will occur on the same day of the month as the issue date.

Please specify **only one** option: ☐ Issue Date of Policy/Contract ☐ Withdrawal on the ____ of each month

SECTION IV - Bank Information

Account Type: ☐ Checking ☐ Savings

We **CANNOT** establish electronic payments without a preprinted voided check or a letter from the bank. Additionally, we **CANNOT** establish electronic payments from starter checks, cash management, brokerage, or mutual fund checks, nor 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.)

IMPORTANT REMINDER-

IN ORDER TO PROCESS YOUR REQUEST
PLEASE TAPE YOUR PREPRINTED VOIDED CHECK OR DEPOSIT SLIP HERE.

Alternatively you may submit a letter on bank letterhead that includes the routing and account numbers.

Banking Institution Routing Number _____ Account Number _____

SECTION V - ACH Withdrawal Authorization

I, the Account Holder, hereby authorize

1. The companies named above (MetLife) to initiate withdrawal entries to the deposit account designated above at the Bank named above, using the Automated Clearing House;
2. Monthly recurring withdrawals; and
3. Withdrawals made from time to time, as I authorize.

I understand that:

1. The origination of electronic withdrawals to my account must comply with the provisions of U.S. law;
2. 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;
3. If payments are made for insurance premiums, paying my insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.

SECTION VI - Signatures

Signature Requirements

All Bank Account Owners must sign this form. Please sign as shown below:

A Partnership	The full name of the firm should be printed with the signature of all general partners (not limited partners).
A Sole Proprietorship	The full name of the business should be printed with the signature of the owner followed by the word "owner."
A Trust	Signatures, followed by the word "Trustee," of all required Trustees. Also submit a Trust Certification, which is available from your representative, sales office, or the appropriate number listed under How to Submit This Form.
A Corporation	The signatures and titles of two officers.
An Individual acting on Behalf of the Owner	The full name of the Owner's fiduciary or agent and the legal documentation of the authority to act (e.g., power of attorney, guardianship papers, etc.).

By signing this document, I accept the term of this EP agreement.

Signature of Owner of the Bank Account ▶ _____ Title (If you are acting in a representative capacity) _____

Print Name of Individual Signing - First _____ Middle _____ Last _____

Signed at City _____ State ☐ Date _____

Signature of Joint Owner of the Bank Account ▶ _____ Title (If you are acting in a representative capacity) _____

Print Name of Individual Signing - First _____ Middle _____ Last _____

Signed at City _____ State ☐ Date _____

Before mailing, please include the following items:

- Preprinted voided check, deposit slip, or a letter from the bank
- All required signatures
- Policy/Contract Number
- Relationships indicated are of the Bank Account Owner to the Insured or Contract Owner

For Sales Office Use Only

Sales Office/Agency Number/Representative ID _____ Date _____

Sales Representative Name - First _____ Middle _____ Last _____

How to Submit this Form

Return pages 1 through 3 of the completed form to the address or fax number listed below for the Company that issued the policy. If policies are issued by more than one Company, return the completed form to any Company that issued at least one of the policies.

Issuing Company	Contact Phone Number	Fax Number	Address
Metropolitan Life Insurance Company MetLife Investors USA Insurance Company First MetLife Investors Insurance Company Metropolitan Tower Life Insurance Company	1-800-638-5433	1-908-655-9581	P. O. Box 354, Warwick, RI 02887-0354
New England Life Insurance Company	1-800-638-5433	1-908-655-9582	P. O. Box 323, Warwick, RI 02887-0323
General American Life Insurance Company MetLife Investors Insurance Company	1-800-638-5433	1-908-655-9583	P. O. Box 355, Warwick, RI, 02887-0355
MetLife Insurance Company of Connecticut **(For Life Insurance Policies Only)**	1-800-638-5433	1-908-655-9584	P. O. Box 321, Warwick, RI 02887-0321
Metropolitan Life Insurance Company **(For Individual Disability Income Policies Only)**	1-800-929-1492	1-908-552-3960	P. O. Box 30591, Tampa, FL 33630-3591

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]:

☐ a majority may act for all

☐ anyone may act alone ☐ all must act unanimously ☐ 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

▶ _____ _____

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
2. 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.
5. The date the Proposed Insured(s) or an Applicant learns that either the Application has been declined or the 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.
6. If the Application is for a Qualified Plan under ERISA, the Proposed Owner learns that either the Application has been declined or the 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.
7. One hundred and twenty (120) days from the date of this Receipt.

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.

Amount Collected

_____

Method of Collection:

- ☐ 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.)

Or receipt of:

- ☐ MetLife Salary Deduction Plan form(s)
- ☐ 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 _____
company

Receipt Date: _____ Title: _____ Sales Office: _____

▶ Producer Signature: _____

Date _____ Signed at City, State _____

Metropolitan Life Insurance Company
New York, NY 10166

Gwenn L. Carr, Senior Vice-President and Secretary

New England Life Insurance Company
Boston, MA 02116

Daniel D. Jordan, Vice-President and Secretary

General American Life Insurance Company
St. Louis, MO 63128

Daniel D. Jordan, Vice-President and Secretary

MetLife Investors USA Insurance Company
Wilmington, DE 19899

Richard C. Pearson, Executive Vice-President

MetLife Investors Insurance Company
St. Louis, MO 63128

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.