MetLife

Policy/Case Number ____________________

Date ____________________

Beneficiary Locator

Metropolitan Life Insurance Company • MetLife Insurance Company of Connecticut • Metropolitan Tower Life Insurance Company • New England Life Insurance Company • First MetLife Investors Insurance Company • MetLife Investors USA Insurance Company

Help us to ensure timely payment to your beneficiaries. Please provide the requested information. This will help us to locate your beneficiaries at the time of claim. This form may not be used to change the information on the application. If you wish to make changes to the application, please contact us. Any information on this form that is in conflict with the application will be disregarded. If you need additional room, please use a second form.

Owner/Insured/Beneficiary Information

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

Owner/Insured/Beneficiary Information - continued

For non-individual owners and beneficiaries, please provide the telephone number of the contact person named on the application. For trusts, please also include the address of the trust.

Entity Name | **Phone Number**

Address | **City** | **State** | **Zip**

Entity Name | **Phone Number**

Address | **City** | **State** | **Zip**

Additional Space

MetLife

Policy Number _____

Additional Person Designated to Receive Lapse and Termination Notices

Company (Check the appropriate ONE.)

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

This form must be completed and returned with a new application for life insurance coverage.

(Owner/Applicant): I hereby designate the person listed below to receive duplicates of notices advising of pending lapse or termination of coverage due to nonpayment of premiums for the life insurance policy referenced above:

☐ I do not wish to name anyone at this time.

Designated Person:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number

_____

▶ Signature of Owner/Applicant _____ Print Name of Owner/Applicant _____

Date _____ Signed at City, State _____

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.

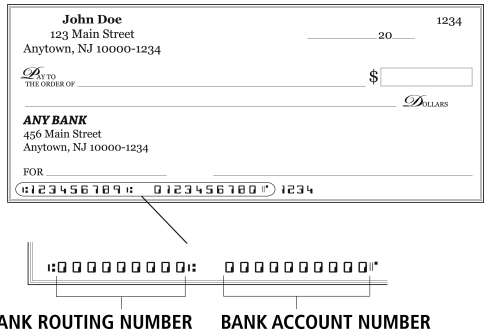
Monthly Debit Date: ☐ Issue Date of the Policy

☐ 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, or its reinsurers, to make a brief report of my personal health information to MIB.
- 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 — First _____ Middle _____ Last _____ Date of Birth _____

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 _____

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

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®

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

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.