

SUBMISSION INSTRUCTIONSFOR THE **SUPPLEMENTAL ENROLLMENT FORM AND THE AUTHORIZATION** THAT FOLLOW BELOW

After completion, make a copy for your records and return the original to

Statement of Health Unit, P.O. Box 14069, Lexington, KY 40512-4069.

Fax: 859-225-7909 or Email: SOHSubmissions@metlife.com.**MetLife**

Metropolitan Life Insurance Company, New York, NY 10166

SUPPLEMENTAL ENROLLMENT FORM**This Supplemental Enrollment Form is required:**

- ▶ If you are enrolling after the initial 90 day enrollment period; or
- ▶ If you are currently enrolled and increasing your coverage by any amount.

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer County of Ventura	Group Customer # 154209	Report Location # 0000154209
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INSURANCE INFORMATION (To be Completed by the Employee)

Enrollment year

Term Life Insurance

- Supplemental/Optional Life: Indicate amount subject to medical underwriting \$ _____
- Dependent Spouse/Domestic Partner ¹ Life: Indicate amount subject to medical underwriting \$ _____

EMPLOYEE INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # - -
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YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner		<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

¹ Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

**GEF02-1
ADM***(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; and***GEF02-1***ADM applies to residents of Connecticut, North Dakota, and Utah)*

HEALTH INFORMATION (To be Completed by the Proposed Insured)

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

Your height ___ feet ___ inches Your weight ___ pounds

1. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? Yes No
2. Are you now receiving or applying for any disability benefits, including workers' compensation? Yes No
3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? Yes No
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
4. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
5. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure? Yes No
6. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:
 - a. cardiac or cardiovascular disorder? Yes No
 - b. stroke or circulatory disorder (such as peripheral artery disease)? Yes No
 - c. cancer, Hodgkin's disease, lymphoma or tumors? Yes No
 - d. diabetes? Yes No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; and

GEF09-1

HEA applies to residents of Connecticut, North Dakota and Utah)

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

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

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; and

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

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

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

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

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(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and GEF09-1

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DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this enrollment form.

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	Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; and GEF09-1

DEC applies to residents of Connecticut, North Dakota and Utah)

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.



Signature of Proposed Insured	Date Signed (MM/DD/YYYY)
Print Name	Country of Birth
State of Birth	

Frequently Asked Questions

Supplemental Enrollment/Statement of Health (SOH) Form

Q. Where do I start?

Complete the Supplemental Enrollment Form/Statement of Health for all amounts you are requesting.

1) Determine Your Coverage Election:

Optional Life

- \$10,000 1x, 2x, 3x Base Annual Earnings, up to a maximum of \$500,000

Dependent Life (Spouse/Domestic Partner, Child)

- Option 1: \$5,000 / \$2,000
- Option 2: \$10,000 / \$5,000

2) Determine Amount Subject to Underwriting

A) How much coverage are you electing? _____

B) How much coverage do you have today? _____

C) A-B = _____ (place this amount on the Supplemental Enrollment form)

Q. What is a Statement of Health (SOH)?

A Statement of Health (SOH) is a document that includes a series of questions about your overall health. Depending on your employer/group's plan and the amount of coverage you request, you may be asked to complete an SOH form in order for MetLife to evaluate your life insurance application.

Q. Why would I be asked to complete a Statement of Health (SOH)?

If you applied for group insurance coverage, you may be required to complete a Statement of Health based on MetLife's rules for your company's group life insurance plan.

Examples of SOH triggers may include:

- You requested coverage after the first 90 days of initial eligibility
- You are currently enrolled and increasing your coverage

Q. What is medical underwriting?

The process by which MetLife evaluates an applicant's eligibility for the group insurance requested based on age, answers on the SOH form and additional medical information, if applicable.

Q. Is the information on my Statement of Health (SOH) form kept confidential?

Yes. We apply strict standards for privacy and confidentiality as with all of our MetLife processes and data.

Q. If I answer "yes" to one of the SOH questions, will I be required to submit additional medical information?

You may be required to provide details explaining your response on the SOH. Once submitted, some answers may require additional medical information in the form of an Attending Physician's Statement (APS) or a paramedical exam, which MetLife will order.

CONTINUED

Q. What is a paramedical exam?

A paramedical exam is a simple physical exam performed by a medical professional that takes approximately 30 minutes, at no cost to you. The exam includes blood and urine samples. If you are required to complete a paramedical exam, you will be contacted by a MetLife approved vendor to schedule an appointment by telephone, e-mail or U.S. mail. You may also initiate scheduling your paramedical exam online if you completed your SOH form online.

Q. Why would I need a paramedical exam?

The need for a paramedical exam is determined by your age, the amount of insurance coverage you are requesting, and your answers on the SOH form. An exam and other medical testing may be required to provide MetLife with the information needed to determine your insurability under the plan.

Q. If I have an existing medical condition and I'm required to complete an SOH, should I still continue with the process?

Yes. Even individuals with relatively serious medical conditions may still be eligible for insurance coverage.

Q. What happens to my Statement of Health (SOH) form once I complete it?

MetLife will review the form and generate a response within 10 business days after receiving the information. The response will either notify you of the final determination regarding your requested insurance coverage or request additional information.

Q. Once I submit my Statement of Health (SOH) form, how can I make changes, if necessary? Please contact the MetLife Statement of Health Unit at 1-800-638-6420 (prompt 1).

Q. What happens if I am declined for this coverage?

If your Statement of Health is declined, it will not affect any coverage already in existence.

Q. Can I dispute a declination?

Yes. You may dispute a declination subject to the terms identified in the declination letter which must include medical documentation to support the reason for the dispute.

Q. If I have questions, who may I contact for help?

For any questions relating to your Statement of Health form, please call 1-800-638-6420, prompt 1. Learn more about Statement of Health process through our interactive online tutorial, by visiting www.metlife.com/sohtutorial.