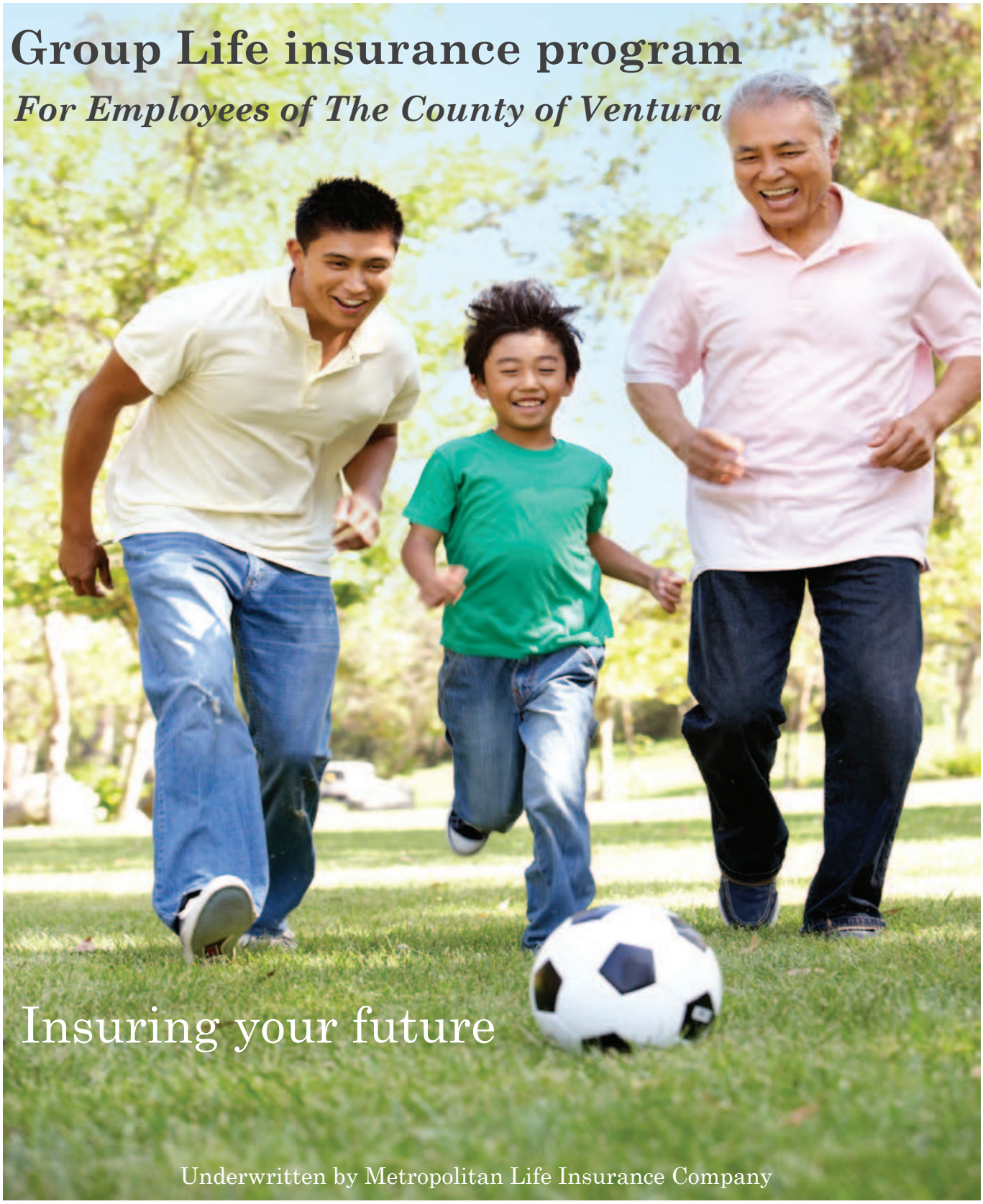
Group Life insurance program

For Employees of The County of Ventura



Insuring your future

Underwritten by Metropolitan Life Insurance Company

MetLife®

Enrollment Information Booklet

Welcome

What do I need to do?

The County of Ventura is proud to partner with Metropolitan Life Insurance Company to provide group life insurance benefits. The County of Ventura group life insurance program offers you an affordable way to provide protection for your family.

Before enrolling, there are two very important questions you need to answer: Why do I need life insurance? and How much do I need?

Why do I need life insurance?

Think about it. If you died what would happen to the people who depend on you for financial support?

Group Term Life insurance provides a base level of protection that can be enhanced by personal savings, individual life insurance and Social Security benefits. This coverage will help protect your family against the unexpected loss of your life and income during your working years.

Insurance proceeds may be used as supplemental income for your family to pay off debts such as mortgage or medical expenses, or could be used to pay for your funeral/burial costs. Other popular uses of proceeds include establishing a college fund for your children or leaving funds for your favorite charities.

How much life insurance do I need?

Everyone's needs are unique and it helps to evaluate your family's financial situation before choosing the exact amount.

Visit our online insurance needs calculator on **http://www.lifeonlinecalculator.com/** to estimate how much.

How do I elect coverage?

This booklet provides information to help you answer those questions and the instructions to enroll for coverage. Enrolling is easy and can be done in four simple steps:

Step 1: Determine your needs

Step 2: Review your coverage options

Step 3: Calculate your costs

Step 4: Enroll

F75111-2 Rev 6-2017

Step 1 Determine your needs

To estimate the amount of life insurance you need, you'll want to determine what you must protect in the event of your death.

Assets & Income

What would be available to your family now, if you weren't here to provide for them?

Spouse/Domestic Partner's annual income x number of years to age 65	$_____
Cash, savings bonds, stocks, securities (current value)	$_____
Company savings plan (401(k), 457, Roth IRA or other)	$_____
Cash value of life insurance	$_____
Other assets* or income (other than your own)	$_____

**Equity in your home, if you plan to sell or borrow against it for cash.*

A = $_____

Basic Necessities

What basic needs do you and your family have?
(multiply the items below by the number of years required, if applicable)

Home – remaining mortgage or rent (120 months is a basic rule of thumb)	$_____
Annual household operating expenses (utilities, food, clothing, insurance, repairs, property taxes, etc.)	$_____
Childcare	$_____
Health – health insurance premiums or medical/hospital expenses not covered by insurance	$_____
Debt – balances on credit cards, car loans, etc	$_____

B = $_____

Comfort Zone

What kind of special or one-time expenses may come along?

Tuition	$_____
Wedding	$_____
New residence	$_____
Elder care x number of years	$_____
Estate taxes, probate fees, attorney fees	$_____
Emergency fund	$_____
Funeral expenses (average is $5,000 - $10,000)	$_____
Golden years (money put aside for survivor's retirement)	$_____

Complete the Equation

Complete the equation that most closely reflects your particular needs:

Basic Necessities	**B - A** = $_____ *(Compare to current Life Insurance amount)*
Comfort Zone	**(B + C) - A** = $_____ *(Compare to current Life Insurance amount)*

Remember, your calculation is based on today's costs and doesn't account for inflation or changes in annual earnings. Review your needs periodically to ensure that your needs will be met now and in the future.

Step 2

Review your coverage options

Now that you understand your need for life insurance and know how much may be enough, you're ready to consider the options available to you under The County of Ventura's group life insurance plan.

Guaranteed coverage opportunity

You may elect guaranteed optional life coverage within the first 90 days of initial eligibility – with no Supplemental Enrollment/Statement of Health (SOH) Form required.

Coverages and amounts available include:

- **For you (Life and AD&D):** $10,000, one times your base annual earnings, two times your base annual earnings, or three times your base annual earnings - not to exceed $500,000.
- **For your spouse/Domestic Partner:** Up to $10,000
- **For your children:** Up to $5,000

What coverage is available?

If eligible, you are automatically enrolled in Basic Life coverage (but must complete the *Basic/Optional Life Insurance Beneficiary Designation Form* to designate your beneficiaries). You may also elect optional coverage for you and your dependents. Electing or increasing coverage after the initial 90-day enrollment period will require you to also complete the *Supplemental Enrollment/Statement of Health (SOH) Form*.

Coverage type	Coverage options	Additional information
Basic Life and Accidental Death and Dismemberment (AD&D)	• $50,000	• All coverage guaranteed • Includes matching AD&D amount
Optional Life and AD&D	• Choice of $10,000, or one, two, or three times your base annual earnings to a maximum of $500,000	• Includes matching AD&D amount • Coverage increases due to salary increase are guaranteed to the plan maximum
Dependent Life	• Option 1: Spouse/Domestic Partner $5,000 Child $2,000 • Option 2: Spouse/Domestic Partner $10,000 Child $5,000	• An employee must be participating in the Optional Life plan to elect dependent coverage • Children are eligible from live birth up to age 26 • Spouses/Domestic Partners and Children can be added within 31 days of marriage/DP or birth/adoption.

Will my benefits reduce?

Reductions in your basic and optional life insurance amount will occur on the beginning of the pay period following your 70th and 75th birthdays. Your life insurance coverage reduces to 65 percent of the face amount on your 70th birthday. It further reduces to 50 percent of the original amount at age 75. All coverage terminates at retirement.

Step 3 Calculate your costs

Review this section to learn about costs associated with coverage. Please note that rates shown are biweekly.

What is the cost for coverage?

Employee Optional Term Life and AD&D

Please note rates increase with age.

Age	Biweekly rate per $1,000
Under 25	$0.030
25-29	0.035
30-34	0.044
35-39	0.049
40-44	0.073
45-49	0.099
50-54	0.141
55-59	0.246
60-64	0.360
65-69	0.593
70 and over	0.958

All rates shown are subject to change.

Dependent Life (biweekly rates)

Option 1: $0.87
Option 2: $1.15

Calculate your costs

Example:

Step 1: Calculate your annual earnings:

$ _____ x 26 pay periods = $ _____

Regular biweekly pay (no overtime)* — Annual Earnings

*For full-time employees, biweekly base salary; For part-time employees, biweekly scheduled hours times hourly rate.

Step 2: Calculate your cost:

$ _____ (Annual Earnings) x _____ (Increments (1x, 2x or 3x)) = $ _____ (Coverage Amount (Round to next $1,000))

$ _____ (Coverage Amount) ÷ $1,000 = _____ (Coverage Units) x _____ (Biweekly Rate) = $ _____ (Biweekly Premium)

Step 4 Enroll

To take advantage of guaranteed coverage amounts, you must enroll within 90 days of your initial eligibility.

Step 1: To elect Optional Life Insurance for yourself, please complete sections A, B, and E on the *Group Life Insurance Enrollment* form.

Step 2: If electing coverage for your dependents, please also complete sections C and/or D on the *Group Life Insurance Enrollment* form.

Step 3: Return completed *Group Life Insurance Enrollment* form to CEO/HR/Benefits (email to Benefits.ServiceRep@ventura.org or brown mail to L#1970).

Step 4: If electing coverage beyond your initial eligibility period or increasing current coverage, please also complete the *Supplemental Enrollment/Statement of Health (SOH) Form* and fax/mail it to MetLife.

Don't forget to sign your completed forms!

Questions?

Please contact the central Benefits Staff at **(805) 654-2570**, or email **Benefits.ServiceRep@ventura.org**.

Frequently asked questions

What is Term Life insurance?

Group Term Life insurance provides affordable protection that is available for a specified period of time. The benefit would be paid if the insured were to die during that "term".

You can buy large amounts of insurance, at a reasonable cost. There is no cash value build up. This coverage can be enhanced by your personal savings, individual life insurance, and social security benefits. If eligible, you are automatically enrolled in Basic Life coverage however, you must enroll in Optional Life coverage.

What is Accidental Death and Dismemberment (AD&D) insurance?

AD&D coverage provides beneficiaries with additional financial protection if an insured person's death is due to a covered accident or provides a benefit if dismemberment occurs as a result of a covered accident. AD&D provides protection for covered accidents occurring at any time, whether at work or elsewhere.

What is included in my life insurance plan?

Beyond paying a benefit in the event of your death, your group life insurance plan has other important features.

- **Waiver of premium** – If you become disabled before age 60, your life insurance premiums may be waived.
- **Accelerated Death Benefit** – If an insured employee becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100 percent of the life insurance amount (Basic and Optional combined).

Can I take my coverage with me if I leave or retire?

If you are no longer eligible for coverage as an active employee, you may port your group life insurance coverage (portable coverage ends at age 70) or you may convert your coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Can I elect additional coverage if I experience a family status change?

Yes**.** You may add coverage for a newly born or newly adopted child or a new spouse or domestic partner without completing the Supplemental Enrollment/Statement of Health (SOH) Form if coverage is elected within 31 days of the birth/adoption or marriage/registration.

How do I pay premiums?

Your life insurance premiums are deducted directly from your paycheck.

Why do I need to designate a beneficiary?

By naming a beneficiary, you are able to ensure that your life insurance benefit is being passed on to those you want to help the most.

Events such as marriage, birth/adoption of children, divorce, or death may dramatically change the intent of how you would want your life insurance benefit paid.

Some common beneficiary choices are:

- **Primary beneficiary** – The person or persons named will receive the benefit.
- **Contingent beneficiary** – If the primary beneficiary is no longer living, the benefit is paid to this person.
- **Default beneficiary** – If you do not name a beneficiary, policy benefits will be paid in order of the policy's default beneficiary definition, as follows – spouse/Domestic Partner, children, parents, brothers and sisters, your estate.

Medical Underwriting process

How does the medical underwriting process work?

- If medical underwriting is required, the applicant will fill out the *Supplemental Enrollment/Statement of Health (SOH) Form* and fax/mail to MetLife.
- Underwriting may approve the coverage without needing additional information, or
- If additional underwriting is required, the applicant may be asked to complete a questionnaire, provide access to medical records, take a medical exam, etc. MetLife will directly notify the applicant of any additional medical requirements and will incur all of the costs associated with the entire underwriting process.
  - If it's determined that an exam is necessary, the applicant is able to schedule an exam over the phone using the instructions provided by MetLife.
- Once all medical underwriting is complete, you will receive written notification from MetLife regarding the underwriting decision.

Tip: To complete the Supplemental Enrollment/Statement of Health (SOH) Form, you should first gather your medical records, including the name and address of physicians, hospitals and clinics you've visited in the past three years, as well as any details regarding diagnosis and treatment.

What is Medical Underwriting?

The process by which MetLife evaluates an applicant's eligibility based on age, answers on the Supplemental Enrollment/Statement of Health (SOH) Form and additional medical information, if applicable.

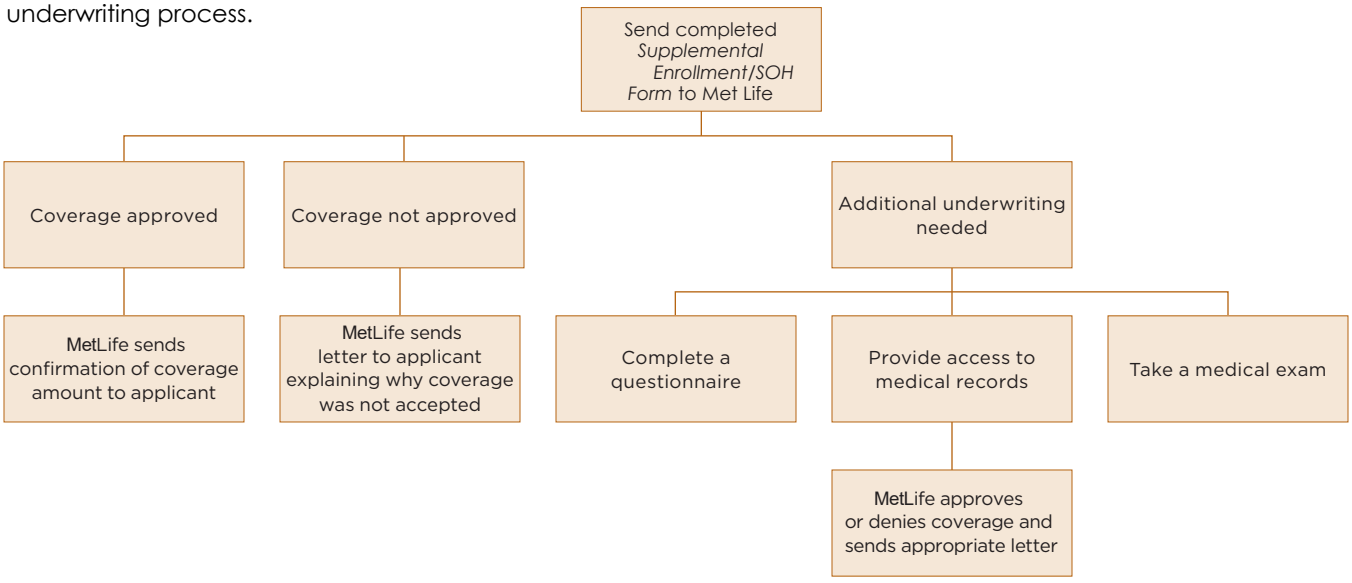
a) electing an insurance amount that exceeds the guaranteed issue limit; or

b) if the employee is applying after the guaranteed issue window; or

c) adding a new spouse/ Domestic Partner to existing dependent life insurance.

Medical underwriting flow chart

The following flow chart provides an overview of the medical underwriting process.



Group Life Insurance Enrollment Form

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura **POLICY NUMBER:** 0154209

1. Complete sections A, B, and E.
2. If electing coverage on your dependents, also complete sections C and/or D.
3. Return completed and signed form to CEO/HR/Benefits (Benefits.ServiceRep@ventura.org or L#1970).

If late enrollment or increasing current coverage, you need to also complete the *Supplemental Enrollment Form/SOH*.

A. EMPLOYEE INFORMATION

First name | Middle initial | Last name

Email address

Street address | City | State | Zip code

Date of birth | Employee ID | Date of employment | Gender ☐ Male ☐ Female

Please select your Optional Life coverage amount

☐ $10,000 ☐ 1x your base annual earnings ☐ 2x your base annual earnings ☐ 3x your base annual earnings

B. BENEFICIARY INFORMATION (EMPLOYEE IS THE BENEFICIARY OF ANY DEPENDENT COVERAGE)

Primary beneficiary full name(s) and address	Date of birth	Relationship	Social Security number	Share % (must total 100%)
Contingent beneficiary full name(s) and address *(Contingent beneficiaries collect only if all primary beneficiaries predecease the insured.)*	**Date of birth**	**Relationship**	**Social Security number**	**Share % (must total 100%)**

Please select your Dependent Life coverage option

☐ Option 1 - Spouse $5,000/ Child $2,000 = $0.87 biweekly ☐ Option 2 - Spouse $10,000/ Child $5,000 = $1.15 biweekly

C. SPOUSE INFORMATION

First name | Middle initial | Last name

Email address

Date of birth | Social Security number | Gender ☐ Male ☐ Female

D. CHILDREN INFORMATION

List of full names and dates of birth for your eligible children

E. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee signature | Daytime phone number | Evening phone number | Date signed

X

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	03-03-1980	123 4th Street, Anywhere, MN 12345, 651-665-3456	XXX-XX-XXXX	Daughter	40%
Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Jones	06-06-1980	5 Main Street, Anywhere, MN 45685, 651-665-6789	XXX-XX-XXXX	Sister	50%
Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Henry Doe - Trustee, his successors or successor in trust under the John Henry Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008. Trust Tax ID number 99-555555.			N/A	Trust	100%

Total = 100%

Example 4: If the beneficiary is a charity/organization.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Charity/Organization Name, 20 Main Street, Anywhere, CA 99999, 805-555-1919			N/A	Charity/ Organization	100%

Total = 100%

Dependent Life Insurance Change Request Form

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura

POLICY NUMBER: 0154209

REASON FOR COMPLETING CHANGE REQUEST:

☐ Adding Dependent(s) - List all eligible being added
☐ Dropping Dependent(s) - List only dependent(s) to drop
☐ Updating Other Information as of: _____ (date)

Eligible Dependents who may be enrolled are:

a. Your legal spouse or domestic partner;
b. Your children from live birth up to age 26 years (a child may only be covered by one parent);
c. Your child who becomes disabled while covered under this Group Policy and is continuously disabled (incapable of self-sustaining employment and chiefly dependent upon you for support and maintenance).

EMPLOYEE INFORMATION (please print)

First name	Middle initial	Last name	Employee ID

DEPENDENT INFORMATION (please print)

Dependent's Full Name (first, middle initial, last)	**Social Security Number**	**Relationship To You**	**Living in Your Home?** (Yes/No)	**Date of Birth**

SIGNATURE REQUIRED

Employee's signature	Date signed
X	

Basic/Optional Life Insurance
Beneficiary Designation Form

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

MetLife®

EMPLOYER NAME: The County of Ventura **POLICY NUMBER:** 0154209

Insured's name (last, first, middle initial)	Insured's employee ID

Address (street, city, state, zip)

Insured's date of birth	Policyowner (if different than the insured)	Policyowner's phone number	Email address

INSTRUCTIONS:

1. Clearly print or type the information below.
2. Sign and date the completed form.
3. Return to CEO/HR/Benefits (Benefits.ServiceRep@ventura.org or L#1970).

This beneficiary designation applies to the coverages noted below:

☐ All group term life coverages **OR** ☐ Basic Life/AD&D only ☐ Optional Life/AD&D only

CHANGE BENEFICIARY REVOKING ALL PRIOR DESIGNATIONS

The primary and contingent beneficiary(ies) determines the order in which beneficiaries become eligible to receive a death benefit. Surviving beneficiaries in any category share equally with beneficiaries in the same category unless otherwise specified. Use of the word "Children" , without modification, includes only your biological children of first generation and adopted children. For revocable designations, this signed beneficiary designation, when accepted by the underwriting company, is the only form needed to elect or change a designation under this policy. No other documents are required.

Name beneficiaries by category. To receive a death benefit, a beneficiary must survive the insured. In the event a beneficiary does not survive the insured, that beneficiary's portion shall be equally distributed to the remaining beneficiaries within that category. In the event of simultaneous death of the insured and a beneficiary, the death benefit will be paid as if the insured survived the beneficiary.

The same person cannot be named as a primary and a contingent beneficiary.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)

Total = 100%

SIGNATURE REQUIRED

Policyowner's signature X	Date

F83345-2 4-2016

EXAMPLES OF BENEFICIARY DESIGNATIONS

Example 1: If a primary beneficiary is to receive the benefit, followed by a contingent beneficiary, if the primary beneficiary is deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Mary Doe	01-01-1980	123 4th Street, Anywhere, MN 12345, 651-665-1234	XXX-XX-XXXX	Daughter	100%

Total = 100%

CONTINGENT BENEFICIARY(IES) - If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s)

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Nancy Doe	02-02-1980	5 Main Street, Anywhere, MN 45685, 651-665-2345	XXX-XX-XXXX	Sister	100%

Total = 100%

Example 2: If more than one primary beneficiary(ies) are to receive the benefit first, followed by the contingent beneficiary(ies) if all of the primary beneficiary(ies) are deceased.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
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Jim Doe	04-04-1980	123 4th Street, Anywhere, MN 12345, 651-665-4567	XXX-XX-XXXX	Husband	40%
Mary Smith	05-05-1980	45 Oak Street, Anywhere, MN 56789, 651-665-5678	XXX-XX-XXXX	Friend	20%

Total = 100%

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Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
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Jack Williams	07-07-1980	10 Elm Street, Anywhere, MN 58978, 651-665-7890	XXX-XX-XXXX	Brother	50%

Total = 100%

Example 3: If the beneficiary is a formal trust.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
John Henry Doe - Trustee, his successors or successor in trust under the John Henry Doe Revocable Trust Agreement. Executed by the insured on June 1, 2008. Trust Tax ID number 99-555555.			N/A	Trust	100%

Total = 100%

Example 4: If the beneficiary is a charity/organization.

PRIMARY BENEFICIARY(IES) - The person or persons named will receive the benefit

Beneficiary Full Name	Date of Birth	Address and Phone Number	Social Security Number	Relationship	Share % (must total 100%)
Charity/Organization Name, 20 Main Street, Anywhere, CA 99999, 805-555-1919			N/A	Charity/ Organization	100%

Total = 100%

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	Group Customer #	Report Location #
County of Ventura	154209	0000154209

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 #
	– –

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee ☐ Self ☐ Spouse/Domestic Partner	☐ Male ☐ 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)*

SUBMISSION INSTRUCTIONS

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

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.

GEF09-1a
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GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

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.

Sign Here

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.

Sign Here

Signature of Proposed Insured		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country 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
     - o ☐ $10,000 ☐ 1x, ☐ 2x, ☐ 3x Base Annual Earnings, up to a maximum of $500,000
   - ☐ Dependent Life (Spouse/Domestic Partner, Child)
     - o ☐ Option 1: $5,000 / $2,000
     - o ☐ 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.

Notes


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