MetLife®
Metropolitan Life Insurance Company, New York, NY

**Small Market Medical Underwriting, PO Box 14593, Lexington, KY 40512-4593, Fax: 1-888-505-7446**

**To be Completed by the Employer** **-PLEASE PRINT CLEARLY-**

| Employer Name | Customer Number | Reporting Location Number | |
|---|---|---|---|
| Employer's Street Address | City | State | Zip Code |

**To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)**

| **Employee Name** (Must Complete) First MI Last | | | **Employee Social Security Number** (Must Complete) | |
|---|---|---|---|---|
| Daytime Phone Number | Date of Full Time Hire (Mo./Day/Yr.) | Work Status: ☐ Active ☐ Retired ☐ Disabled | Employee's Annual Salary $ | |
| Insurance is for ☐ Employee ☐ Spouse ☐ Child | Proposed Insured Name First MI Last | | ☐ Male ☐ Female | Date of Birth (Mo Day Yr) |
| Mailing Address | City | | State | Zip Code |
| Business Phone Number ( ) | Home Phone Number ( ) | E-mail Address | State of Birth | Country of Birth |

**Total Insurance Requested (To be completed for each Applicant)**

☐Basic Life (or Core) $_____ ☐Optional Life (or Buy-Up) $_____ ☐Short Term Disability $_____

☐Dependent Life (or Buy-Up) $_____ ☐Long Term Disability $ _____

**GEF02-1**
**ADM**

**Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.**

1. Height ____ feet ____ inches Weight ____ lbs

| | Yes | No |
|---|---|---|
| 2. Are you now: | | |
| a. pregnant? | ☐ | ☐ |
| b. taking prescribed medications or on a prescribed diet? If "yes," list:_____ | ☐ | ☐ |
| c. receiving or applying for any disability benefits including workers' compensation? | ☐ | ☐ |
| 3. In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? | ☐ | ☐ |
| 4. In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.)_____ | ☐ | ☐ |

5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| a. chest pain or heart trouble? | ☐ | ☐ | h. colitis, Crohn's or any intestinal disorder? | ☐ | ☐ |
| b. high blood pressure, stroke or circulatory disorder? | ☐ | ☐ | i. Epilepsy, paralysis or dizziness? | ☐ | ☐ |
| c. cancer or tumors? | ☐ | ☐ | j. mental or nervous disorder? | ☐ | ☐ |
| d. anemia, leukemia or other blood disorder? | ☐ | ☐ | k. Lyme disease, Epstein-Barr or chronic fatigue syndrome? | ☐ | ☐ |
| e. diabetes? | ☐ | ☐ | l. arthritis, carpal tunnel, or any muscle weakness? | ☐ | ☐ |
| insulin treated? | ☐ | ☐ | m. kidney or urinary tract disorder? | ☐ | ☐ |
| f. asthma, tuberculosis, pneumonia, or other lung disease? | ☐ | ☐ | n. thyroid or other gland disorder? | ☐ | ☐ |
| g. ulcers, stomach or liver disorder? | ☐ | ☐ | o. back, neck or spinal disorder? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| 6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | ☐ | ☐ |

7. Personal Physician:_____ Date and reason for last visit:_____
Address:_____ Phone Number:_____

**Give full details for "Yes" answers on the next page.**



**Make A Copy For Your Records & FAX or MAIL Completed Forms to**
**Small Market Medical Underwriting, 1-888-505-7446, MetLife, PO Box 14593, Lexington, KY 40512-4593**

**Give full details for "Yes" answers.** If more space is needed for full details, attach a separate sheet, sign and date it.

| Question Number | Dates of Treatment | Diagnosis/Condition | Duration | Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**GEF02-1** **CA**
**MQ**

**Declaration** — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

**Fraud Warning:**

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

**New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.**

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

**Massachusetts: 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, and may subject such person to criminal and civil penalties.**

**New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

**Oklahoma: 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.**

**Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.**

**Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.**

**Virginia 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 include imprisonment, fines and denial of insurance benefits.**

**All other states:**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.**

| Sign Here | | Date Here | |
|---|---|---|---|
| | (Employee must always sign)<br><br>Signed | | Date Signed (Mo./Day/Yr.) |
| | (Proposed Insured if other than Employee and at least 18 years of age)<br><br>Signed | | Date Signed (Mo./Day/Yr.) |



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# Authorization

**In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:**

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
  - 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; and
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

**Expiration, Revocation and Refusal to Sign:** This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, 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.
- Each proposed insured has a right to receive a copy of this form.

**A photocopy of this form is as valid as the original form.**


_____

Signature of Proposed Insured or
Signature & Relationship of Personal Representative*


_____

Date Signed (Mo./Day/Yr.)

_____

Print Name of Proposed Insured

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

MetLife

# Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

## Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

## Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

## Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

## How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

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

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

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, MA 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.

## Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

## Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

### HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

## Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

## Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

**Send privacy questions to**:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company**
**General American Life Insurance Company**
**SafeGuard Life Insurance Company**
**MetLife Insurance Company of Connecticut**
**SafeGuard Health Plans Inc.**