Messiah College Plan Benefits

Explore the coverage that makes it easy to give yourself and your loved ones more security today...and in the future.

Supplemental Term Life Insurance Coverage Options

<table>
<thead>
<tr>
<th>For You</th>
<th>$10,000 to $500,000 in $5,000 increments to a maximum of 5 times your basic annual earnings or $500,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>For Your Spouse</td>
<td>$5,000 to $150,000 in $5,000 increments</td>
</tr>
<tr>
<td>For Your Dependent Children*</td>
<td>$2,000 to $10,000 in $2,000 increments</td>
</tr>
</tbody>
</table>

*Child(ren)'s Eligibility: Dependent children ages from 15 days to 19 years old, or 23 years old if a child is a full-time student, are eligible for coverage.

Monthly Costs for Supplemental Term Life Insurance

You have the option to purchase Supplemental Term Life Insurance. Listed below are your monthly rates as well as those for your spouse (based on your age and the amount of coverage you want). Rates to cover your child(ren) are also shown.

<table>
<thead>
<tr>
<th>Age</th>
<th>Your Monthly Cost Per $1,000 of Coverage</th>
<th>Spouse Monthly Cost Per $1,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.03</td>
<td>$0.06</td>
</tr>
<tr>
<td>25 - 29</td>
<td>$0.04</td>
<td>$0.08</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.05</td>
<td>$0.10</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.07</td>
<td>$0.11</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.10</td>
<td>$0.14</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.15</td>
<td>$0.20</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.23</td>
<td>$0.38</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.41</td>
<td>$0.63</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.56</td>
<td>$1.16</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$1.06</td>
<td>$1.98</td>
</tr>
<tr>
<td>70 +</td>
<td>$1.71</td>
<td>$2.95</td>
</tr>
<tr>
<td>Cost for your Child(ren)†</td>
<td>$0.11</td>
<td></td>
</tr>
</tbody>
</table>

† Covers all eligible children
Use the table below to calculate your premium based on the amount of life insurance you will need. 

Example: $100,000 Supplemental Life Coverage

1. Enter the rate from the table (example age 36)
   $0.07 $ ___________

2. Enter the amount of insurance in thousands of dollars
   (Example: for $100,000 of coverage enter $100)
   100 $ ___________

3. Monthly premium (1) x (2)
   $7.00 $ ___________

Repeat the three easy steps above to determine the cost for each coverage selected.

Features

This insurance offering from your employer and MetLife comes with a variety of added features that can provide assistance to you and your family members today and during a difficult time.

Accelerated Benefits Option*

For access to funds during a difficult time

You can receive up to 80% of your Supplemental Term Life insurance proceeds to a maximum of $500,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time. The Accelerated Benefit Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

*The Accelerated Benefits Option is subject to state availability and regulation. The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable federal tax treatment. If the accelerated benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation.

This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.

Conversion

For those who wish to have more permanent coverage

You can generally convert your Group Term Life insurance benefits to an Individual Whole Life insurance policy if your coverage terminates in whole or in part due to your retirement, termination of employment, or a change in your employee class. Conversion is available on all Group Life insurance coverages. If you experience an event that makes you eligible to convert your coverage, you can speak with a MetLife representative by calling: 1-877-275-6387.

Waiver of Premiums for Total Disability (Continued Protection)

Offering continued coverage at no cost

You may be eligible to waive your Supplemental and Dependent Term Life insurance premium until you reach age 65, die or recover from your disability, whichever is sooner, should you become unable to work due to total disability. Total disability or totally disabled means your inability to do your job and any other job for which you are fit by education, training or experience, due to injury or sickness. The total disability must begin before age 60, and your waiver will begin after you have satisfied a 9-month waiting period. The Waiver of Premium will end on the earliest of your turning age 65 death or recovery. Please note that this benefit is available after you have participated in the Supplemental Term Life Plan for one year and it is only available to you. This one-year requirement applies to new participants in the plan.
Portability

*So you can keep your coverage even if you leave your current employer*

Should you leave Messiah College for any reason, and your Supplemental and Dependent Term Life insurance under this plan terminates, you will have an opportunity to continue group term coverage ("portability") under a different policy, subject to plan design and state availability. Competitive rates apply, but will likely be higher than your current rates. MetLife will bill you directly. To take advantage of this feature, you must have coverage of at least $20,000 up to a maximum of $1,000,000.

Portability is also available on coverage you’ve selected for your spouse and dependent child(ren). The maximum amount of coverage for spouses is $250,000; the maximum amount of dependent child coverage is $25,000. Increases, decreases and maximums are subject to state availability.

Generally, there is no minimum time for you to be covered by the plan before you can take advantage of the portability feature. Please see your plan administrator or certificate for specific details. Please note that if you experience an event that makes you eligible for portable coverage, please call a MetLife representative at 1-866-492-6983 or contact your employer for more information.
Will Preparation Service†
To ensure your decisions are carried out

Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have access to Hyatt Legal Plans’ network of 11,000+ participating attorneys. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney.* To obtain the legal plan’s toll-free number and your company’s group access number, contact your employer or your plan administrator for this information.

†Will Preparation Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, Will Preparation Services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. In some states, Will Preparation is subject to regulatory approval and is not currently available.

* You also have the flexibility of using an attorney who is not participating in the Hyatt Legal Plans’ network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney’s fees that exceed the reimbursed amount.

MetLife Estate Resolution Services—ERS‡
Personal service and compassion to help your beneficiaries manage your estate during their time of need

MetLife Estate Resolution Services—is a valuable service offered at no additional cost to you. A Hyatt Legal Plan attorney will consult your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator. You can feel confident that your executor or administrator will have access to the advice that is needed to properly settle your estate. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

‡Estate Resolution Services are offered by Hyatt Legal Plans, Inc., Cleveland, Ohio. In certain states, Estate Resolution Services are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. In some states, Estate Resolution Services are subject to regulatory approval and are not currently available. The following are not covered by the service: Matters in which there is a conflict of interest between the executor, administrator, any beneficiary or heir and the estate; any disputes with the Policyholder, Employer, Plan Attorneys, MetLife and/or any of its affiliates; any disputes involving statutory benefits; Will contests or litigation outside Probate Court; Appeals; Court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

MetLife Advice**
Assistance identifying solutions for your financial situations

MetLife Advice is a service designed to help provide assistance in making financial decisions based on the major events in your life such as marriage, the birth of a child, purchase of a home, death of a spouse or retirement. Contact your employer or plan administrator for more information.

**MetLife Advice Specialists are Financial Services Representatives of MetLife or New England Financial, a MetLife company.

MetLife Advice for Beneficiaries—Delivering The Promise®
For support and guidance when beneficiaries need it most

MetLife Advice for Beneficiaries—Delivering The Promise® is a service designed to provide beneficiaries with the support and assistance they need during an especially difficult time. Services include assistance filing life insurance claims and consultation to help with the financial details and questions that arise upon the loss of a loved one.
MetLife’s Division of Estate Planning (MetDESK®)††
MetLife’s Division of Estate Planning for Special Kids (MetDESK®)

MetDESK is a service that works with families who have children with special needs to help them prepare for the complex financial, social, emotional, and educational issues facing them. MetDESK helps families with financial and estate planning, strategies for education, and government eligibility issues.

††MetDESK, MetLife’s Division of Estate Planning for Special Kids. Investment advisory services offered by MetLife Securities, Inc., 200 Park Avenue, NY, NY 10166.

Total Control Account®
For immediate access to death proceeds

The Total Control Account® settlement option provides your loved ones with a safe and convenient way to manage the proceeds of a life policy for claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited check-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

What’s Not Covered?

Like most insurance plans, this plan has exclusions. For instance, Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage.
Additional Coverage Information

How To Apply*
Complete your enrollment form and return it to your Human Resources Manager today! Be sure to indicate your Beneficiary. You may enroll for life insurance coverage quickly and securely online using the “MyBenefits” website from MetLife. It’s easy to use. Just go to www.metlife.com/mybenefits.

Act Now During the Enrollment Period.

Note: If you do not wish to make a change to your coverage, you do not need to do anything.

*Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit a Statement of Health to complete your application for coverage.

For Employee Coverage
Enrollment in this Supplemental Term Life insurance plan is available without providing a Statement of Health form as long as:

For Annual Enrollment
• Your enrollment takes place before the enrollment deadline and
• You are continuing the coverage you had in the last year

For New Hires
• Your enrollment takes place within 31 days from the date you become eligible for benefits, and
• You are enrolling for coverage equal to/less than $150,000

If you do not meet all of the conditions stated above, you will need to provide additional medical information by completing a Statement of Health form. A Statement of Health is included in this booklet.

For Dependent Coverage†
Your spouse/domestic partner and dependent children also do not need to provide a Statement of Health form as long as they are not home or hospital confined and not receiving disability payments and:

†A domestic partner declaration may be required for those partners not registered with a government agency where such registration is available.

For Annual Enrollment
• The enrollment takes place prior to the enrollment deadline, and
• Your spouse and child(ren) is continuing coverage s/he/they had in the last year

For New Hires
• The enrollment takes place within 31 days from the date you become eligible for benefits, and
• Your spouse is enrolling for coverage equal to/less than $25,000

If you do not meet all of the conditions stated above, you will need to provide additional medical information by completing a Statement of Health form. A Statement of Health is included in this booklet.
Who Can Be A Designated Beneficiary?
You can select any beneficiary(ies) other than your employer, and you may change your beneficiary(ies) at any time. You can also designate more than one beneficiary.

About Your Coverage Effective Date
You must be “Actively at Work” on the date your coverage becomes effective, and your spouse and eligible child(ren) must be performing their Normal Activities when coverage becomes effective. Coverage will become effective on date following the receipt of your completed enrollment form for all requests that do not require additional medical information. Requests for amounts that require additional medical information and are not approved by the date listed above will not be effective until the first of the month following approval from MetLife or the date that Actively at Work and Normal Activities requirements are met.

This summary provides an overview of your plan’s benefits. These benefits are subject to the terms and conditions of the contract between MetLife and Messiah College and are subject to each state’s laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

Life coverage is provided under a group insurance policy (Policy Form GPNP99) issued to your employer by MetLife. Life coverage under your employer’s plan terminates when your employment ceases, when your Life contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent or when a dependent spouse reaches age 70. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.
ENROLLMENT FORM FOR MESSIAH COLLEGE
SECTION TO BE COMPLETED BY EMPLOYER

<table>
<thead>
<tr>
<th>Name of Employer</th>
<th>Group Customer #</th>
<th>Report #</th>
<th>Sub Division</th>
<th>Branch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Messiah College</td>
<td>141879</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Employer’s Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Employee’s Work Location</th>
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<tbody>
<tr>
<td>One College Avenue</td>
<td>Grantham</td>
<td>PA</td>
<td>17027</td>
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<table>
<thead>
<tr>
<th>Date of Hire (Mo./Day/Yr.)</th>
<th>Employee’s Basic Annual Earnings (BAE) $</th>
<th>Employee’s Occupation</th>
<th>Coverage Effective Date (Mo./Day/Yr.)</th>
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</table>

<table>
<thead>
<tr>
<th>Work Status:</th>
<th>Hours Worked Per Week</th>
<th>Work Status:</th>
<th>Coverage Effective Date (Mo./Day/Yr.)</th>
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</thead>
<tbody>
<tr>
<td>New Hire</td>
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<td>Active</td>
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<tr>
<td>Rehire</td>
<td>Hourly Paid</td>
<td>Retired</td>
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<td></td>
<td>Salaried</td>
<td>Disabled</td>
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<td></td>
<td>Part-Time</td>
<td>On Layoff/Leave of Absence</td>
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</tbody>
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<thead>
<tr>
<th>Reason for Enrollment:</th>
<th>New Coverage</th>
<th>New Hire/First Time Eligible</th>
<th>Late Enrollee (Statement of Health Required)</th>
<th>Change in Coverage Amount Requested</th>
<th>Change in Enrollment Other Than Coverage Amount</th>
<th>Family Status Change (not applicable to new enrollments)</th>
<th>Date (Mo./Day/Yr.)</th>
</tr>
</thead>
</table>

SECTION TO BE COMPLETED BY EMPLOYEE

<table>
<thead>
<tr>
<th>Name (print)</th>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Social Security #</th>
<th>Date of Birth (Mo./Day/Yr.)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Marital Status:</th>
<th>Single</th>
<th>Married</th>
<th>Widowed</th>
<th>Divorced</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>E-mail Address</th>
<th>Phone No. (include area code)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

COVERAGE REQUEST DATA:
I have received and read a copy of my employer’s current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage
☐ Supplemental/Optional Life
   You may elect a multiple of $10,000 up to a maximum of $500,000.
   Note: Amounts exceeding $150,000 require a Statement of Health form.
   Amount Requested: $__________

Dependent Spouse Coverage
☐ Dependent Spouse Life*
   You may elect a multiple of $5,000 up to a maximum of $150,000.
   Note: Amounts $25,000 require a Statement of Health form.
   Amount Requested: $__________

Dependent Child Coverage
☐ Dependent Child Life*
   Options:
   ☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000
   *Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse) _____

Name of Spouse (Last, First, MI) ___________________________ Date of Birth __________ Sex (M/F) _______

Name(s) of Child(ren) (Last, First, MI) ___________________________ Date of Birth __________ Sex (M/F) _______ Is child a full-time student? ☐ Yes ☐ Yes ☐ Yes ☐ Yes

GEF02-1 Please Retain A Copy of The Fully-Completed Form For Your ADM Records And Return The Original To Your Employer (Continued on Following Page) Messiah College (05/09)
DECLARATION SECTION
Each person signing below declares that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee declares that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition, if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician’s care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option
Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires
I understand that if life coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

For Payroll Deduction Authorization By The Employee
I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

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.

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.

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.

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.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.

<table>
<thead>
<tr>
<th>Primary Beneficiary Full Name (Last, First, Middle Initial)</th>
<th>Relationship</th>
<th>Date of Birth (Mo./Day/Yr.)</th>
<th>Address (Street, City, State, Zip)</th>
<th>Share %</th>
</tr>
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<tbody>
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Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL: 100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

<table>
<thead>
<tr>
<th>Contingent Beneficiary Full Name (Last, First, Middle Initial)</th>
<th>Relationship</th>
<th>Date of Birth (Mo./Day/Yr.)</th>
<th>Address (Street, City, State, Zip)</th>
<th>Share %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL: 100%

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature ___________________________ Print Name ___________________________ Date Signed (Mo./Day/Yr.) ___________________________
INSTRUCTIONS
FOR THE STATEMENT OF HEALTH FORM AND THE AUTHORIZATION FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)
1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE
1. Fill in your name and Social Security Number on the Statement of Health form. The Employee's Name and the Employee’s Social Security Number must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee’s Spouse or the Employee’s Child.) A separate Statement of Health form must be completed by each Proposed Insured.

Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee’s request for group insurance coverage for you, the Proposed Insured.
1. The Employee should fill in the Employee's name and Social Security Number and give the form to you.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX or MAIL the original forms to: MetLife Global Operations Support Center Private Limited.

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoi@metlife.com.

Note: Additional medical information may be required after MetLife’s initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company’s obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

<table>
<thead>
<tr>
<th>Name of Group Customer/Employer/Association</th>
<th>Group Customer #</th>
<th>Reporting Location #</th>
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</thead>
<tbody>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State Zip Code</td>
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</table>

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Term Life Insurance
- [ ] Basic Life: Indicate amount subject to medical underwriting $________
- [ ] Supplemental/Optional Life: Indicate amount subject to medical underwriting $________
- [ ] Dependent Spouse Life: Indicate amount subject to medical underwriting $________
- [ ] Dependent Child Life: Indicate amount subject to medical underwriting $________

Enrollment year

EMPLOYEE INFORMATION (To be Completed by the Employee)

<table>
<thead>
<tr>
<th>Name of Employee (First, Middle, Last)</th>
<th>Social Security # of Employee</th>
</tr>
</thead>
</table>

YOUR INFORMATION (To be Completed by the Proposed Insured)

<table>
<thead>
<tr>
<th>Name (First, Middle, Last)</th>
<th>Relationship to Employee</th>
<th>Relationship Type</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Self Spouse Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
<td>State Zip Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Birth (MM/DD/YYYY)</td>
<td>Daytime Phone #</td>
<td>Home Phone #</td>
<td>Email Address</td>
<td></td>
</tr>
</tbody>
</table>

1 For Vermont and Washington State residents, Spouse 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.
HEALTH INFORMATION

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 Social Security/Identification # ___________________________

1. Your height ___ feet ___ inches      Your weight ___ pounds
   
2. Are you now on a diet prescribed by a physician or other health care provider? If “yes” indicate type ___________________________
   Yes   No

3. Are you now pregnant? If “yes,” what is your due date (month/day/year)? ___________________________
   Yes   No

4. Are you now, or have you in the past 5 years, used tobacco in any form? ___________________________
   Yes   No

5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? ___________________________
   Yes   No

6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If “yes”, specify “date(s) of conviction(s) (month/day/year) ___________________________
   Yes   No

7. 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

8. Are you now receiving or applying for any disability benefits, including workers’ compensation? ___________________________
   Yes   No

9. 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.

10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? ___________________________
    Yes   No

11. 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? ___________________________
      Yes   No

   c. high blood pressure? ___________________________
      Yes   No

   d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type ___________________________
      Yes   No

   e. anemia, leukemia or other blood disorder? Indicate type ___________________________
      Yes   No

   f. diabetes? Your age at diagnosis? ______  □ Check if insulin treated ___________________________
      Yes   No

   g. asthma, COPD, emphysema or other lung disease? Indicate type ___________________________
      Yes   No

   h. ulcers, stomach, hepatitis or other liver disorder? Indicate type ___________________________
      Yes   No

   i. colitis, Crohn’s, diverticulitis or other intestinal disorder? Indicate type ___________________________
      Yes   No

   j. memory loss? ___________________________
      Yes   No

   k. epilepsy, paralysis, seizures, dizziness or other neurological disorder?
      Specify date of last seizure (month/year) ______  Indicate type ___________________________
      Yes   No

   l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? ___________________________
      Yes   No

   m. multiple sclerosis, ALS or muscular dystrophy? ___________________________
      Yes   No

   n. lupus, scleroderma, auto immune disease or connective tissue disorder? ___________________________
      Yes   No

   o. arthritis? □ osteoarthritis □ rheumatoid □ other/type ___________________________
      Yes   No

   p. back, neck, knee, spinal, joint or other musculoskeletal disorder? ___________________________
      Yes   No

   q. carpal tunnel syndrome? ___________________________
      Yes   No

   r. kidney, urinary tract or prostate disorder? Indicate type ___________________________
      Yes   No

   s. thyroid or other gland disorder? Indicate type ___________________________
      Yes   No

   t. mental, anxiety, depression, attempted suicide or nervous disorder? ___________________________
      Yes   No

   u. sleep apnea ___________________________
      Yes   No

For “yes” answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are answered “no,” you may proceed directly to Section 3 on the next page.
SECTION 2 – Please provide full details below for each “Yes” answer to the preceding questions 1-11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Condition/Diagnosis</th>
<th>Medication Prescribed</th>
</tr>
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Date of Diagnosis (Month/Year)  
Date of Last Treatment (Month/Year)  
Type of Treatment  

Treating Health Professional  
Personal Physician’s Name:  
Date of last visit:  
Reason for visit:  
Address:  
Telephone:  

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Personal Physician’s Name:  
Date of last visit:  
Reason for visit:  
Address:  
Telephone:  

SECTION 3  

1. Personal Physician’s Name:  
Address (Street, City, State, Zip Code):  
Date of last visit (MM/DD/YYYY):  
Reason for visit:  

2. Are you currently taking any other prescribed medications?  
   Medication:  
   Prescribing Physician’s Name:  
   Address (Street, City, State, Zip Code):  

GEF09-1  
HEA
FRAUD WARNINGS

Before signing this Statement of Health 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.

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, 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 may include imprisonment, fines or a denial of insurance benefits.

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 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.

Oregon and 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.

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.

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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DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health 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 my insurability.

2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

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

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. 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.

Signature of Personal Representative  Print Name  Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

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DEC
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 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.

If a child proposed for insurance is age 18 or over, the child must sign this Authorization form. 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.

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

Signature of Personal Representative Print Name Date Signed (MM/DD/YYYY)
Relationship of Personal Representative

AUTH-XDP110M-NW (03/13)