

Term Conversion Application

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

Metropolitan Tower Life Insurance Company
5601 South 59th Street
Lincoln, NE 68516

**BELOW ARE INSURANCE FRAUD WARNING STATEMENTS THAT APPLY TO RESIDENTS OF SPECIFIC STATES.
PLEASE READ IF THE STATE IN WHICH YOU RESIDE IS LISTED.**

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or any 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.

Florida

Any person who knowingly and with the 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.

Colorado, Washington, Maine, Oklahoma, Tennessee, Virginia

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 denial of insurance benefits.

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.

Application Completion Instructions:

This application is for use with full or partial term conversions for a principal insured on a single life existing policy and/or rider where evidence of insurability is not required.

If additional insurance over the conversion amount is requested or riders or benefits that require evidence of insurability are requested, please complete the long form application.

This application is not to be used when evidence of insurability is required.

4) Existing or applied for insurance, including any term riders, or annuity: (If additional space is needed, provide details in the Supplemental Information Section.) If no existing or applied for insurance or annuity, check here .

(Type: Life (L), Disability (D), Health (H), Annuity (A))

Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	RPL	1035
						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
						<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

5) **REPLACEMENTS**

In connection with this conversion application, has there been or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction involving an annuity or other life insurance? (If Yes, check "Yes" in the RPL column above for all policies that will be replaced and indicate whether the replacement will involve a 1035 Exchange. Also complete the Replacement Questionnaire and Disclosure and any applicable replacement forms. Check No if this term conversion is an exempt replacement transaction.) Yes No

6) Is any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) Yes No

a) Amount of insurance on spouse: Existing: \$ _____ Applied For: \$ _____

b) If dependent minor, are there any other siblings insured for less than this child is? (If Yes, provide details in Supplemental Information Section.) Yes No

c) Amount of existing and applied for insurance on parents of dependent minor:

Father's Name	Amount		Mother's Name	Amount	
	Existing	Applied For		Existing	Applied For

7) **MODE OF PAYMENT:** Complete only if the mode of payment is different from the existing policy.

a) Mode of Payment: Annual Semiannual Quarterly Monthly Bank Draft
 Special Accts _____ Other _____

(Additional details/ existing/new account numbers, etc.): _____

b) Amount collected with application \$ _____ is is not equal to at least one monthly premium.

8) **SOURCE OF FUNDS** (planned premium/excess premium): (Check all that apply.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Earned Income | <input type="checkbox"/> Money Market Fund | <input type="checkbox"/> Certificate of Deposit |
| <input type="checkbox"/> Rollover/Transfer of Assets | <input type="checkbox"/> Savings | <input type="checkbox"/> Loan <input type="checkbox"/> Other |
| <input type="checkbox"/> Mutual Fund/Brokerage Acct. | <input type="checkbox"/> Use of values in another Life Insurance/Annuity Contract | |

9) What is the purpose of this insurance? Family Protection Business Estate Planning Retirement
 Mortgage Education Funding Final Expenses Special Needs Other

OWNER/BENEFICIARY:

Check here if the Owner and Beneficiary designations shown below will also apply to the original existing policy referenced in Question 1 of this application.

Provide the following information for all Primary/Contingent Owners and Beneficiaries: name; relationship to Insured; date of birth; social security/tax ID number; citizenship; mailing address (and residence address if different). If Trust, Trustee Name and Date of Trust.

<p>10) Identity of Owner: <input type="checkbox"/> Insured</p>	<p>11) Identity of Contingent Owner (if applicable):</p>
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Note: Multiple Beneficiaries will receive equal proceeds unless otherwise requested by Owner. Indicate additional Beneficiaries/ Contingent Beneficiaries in Supplemental Information Section.

<p>12) Identity of Primary Beneficiary: <input type="checkbox"/> Owner</p>	<p>13) Identity of Contingent Beneficiary:</p>
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Check here if all present and future children born of the marriage of the Insured, (name) _____ , and current spouse, (name) _____ , are to be included as Contingent Beneficiaries.

<p>14) ADDRESS OF INSURED: Complete only if the addresses are different from the existing policy.</p>	
<p>Insured's current residence address:</p> <p>_____</p> <p>(Street)</p> <p>_____</p> <p>(City/State) (Zip)</p>	<p>Premium Payer's name and mailing address: (If name or address is different than Insured's.)</p> <p>_____</p> <p>(Name)</p> <p>_____</p> <p>(Street)</p> <p>_____</p> <p>(City/State) (Zip)</p>

Supplemental Information Section or Special Requests from Agent/Producer to Company

Home Office Endorsements: (Not applicable to: FL, KY, MD, MA, MN, MO, NH, OR, PA, PR, WV, WI.)

AGREEMENT/DISCLOSURE

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- In this Agreement, “the Company” means the insurer that issues the new or changed policy(ies) and/or rider(s).
- My acceptance of any insurance policy means I agree to any changes shown in the Home Office Endorsements section, where state law permits Home Office endorsements.
- This application and any amendment(s) and supplement(s) will be attached to and become part of the new or changed policy(ies).
- The basis of any policy and/or rider are:
 - My statements in this application and any amendment(s) and supplement(s); and
 - My statements in the application(s), amendment(s), paramedical/medical exam, questionnaire(s) and supplement(s) for the original policy(ies) and/or rider(s).
- Only the Company’s President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, policy, or rider.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 5 of this application.
- I have received the Company’s Consumer Privacy Notice and, as required, the Life Insurance Buyer’s Guide.

I also agree that:

- The answers given in this application may be relied upon in deciding whether to grant a conversion. Any conversion provided in reliance on such answers is contestable to the extent set forth in the resulting policy(ies) and/or rider. However, where coverage provided under the original policy(ies) and/or rider continues, such coverage remains contestable as set forth in the original policy(ies) and/or rider.
- The Company will not be liable under this application until a new policy(ies) and/or rider is delivered and any premium due is paid.
- Any new policy will be subject to any assignment of or restriction on the original policy(ies). Except where the original policy(ies) stay(s) in force, any policy loan will be charged to the new policy(ies) as a policy loan. It will be subject to the terms of the new policy(ies).
- Any dividend held under the original policy(ies), or other credit from the conversion, will: (a) be transferred to the new policy(ies); or (b) paid to the owner(s) of the new policy(ies); or (c) remain with the original policy(ies).

Substitute Form W-9 - Request for Taxpayer Identification Number

Owner's Taxpayer Identification Number: _____

Under penalties of perjury I _____ certify:
(Owner's Name)

- 1) That the number shown above is my correct taxpayer identification number; and
- 2) That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and
- 3) I am a U.S. citizen or a U.S. resident for tax purposes.*

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form W-8BEN.

SIGNATURES:

	Signed at City, State	Mo./Day/Year	Signature
Owner Before Change* (age 15 or over)	_____	_____	_____
Owner After Change* (if different) (age 15 or over)	_____	_____	_____
Collateral Assignee (before change, if any)	_____	_____	_____
Insured (age 15 or over)	_____	_____	_____
Parent or Guardian or person liable for child's support (Signature required if Owner or Insured is under the age of 18 and the parent, guardian or person liable for the child's support has not signed above.)	_____	_____	_____
Witness to Signatures (Licensed Agent/Producer)	_____	_____	_____

*If the Owner is a Firm or Corporation, include Officer's title with signature. (Officer signing must be other than the Insured.)