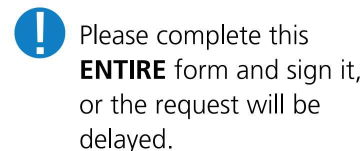
MetLife

Application for Life Insurance Policy Reinstatement

Use this form to provide the information we need to review the request to reinstate the life insurance policy.

This form applies to the MetLife companies listed below.

☐ Metropolitan Life Insurance Company
☐ Metropolitan Tower Life Insurance Company



Things to know before completing the application

- If multiple people are insured on the Policy, a separate application for each Insured is required for us to consider the request for reinstatement.
- Section 2 of this application must be completed by the Insured, unless the Insured is a minor. If the Insured is a minor, the Insured's parent or guardian should complete Section 2.
- The detailed medical records for the Insured are needed to complete Section 2.

Information we need

- Who is the Insured on the Policy
- The Insured's health information
- Owner information
- Signatures

Definitions

- Owner: The person, business, trust or entity with the right to make all decisions regarding the Policy.
- Insured: The person insured by the Policy and upon whose death the Beneficiaries will receive the proceeds of the claim. The Insured may also be the Owner.

Section 1: Who Is the Insured on the Policy

Policy number ______________________

First name	Middle name	Last name	Suffix

Address

City	State	ZIP	Social security number

Primary phone number	Alternate phone number	Email address

Date of birth

Section 2: General Health Information

Unless the Insured is a minor, this Section must be completed by the Insured. If the Insured is a minor, the Insured's parent or guardian must complete this Section on behalf of the Insured. Answer all questions and provide details for all "Yes" responses where indicated. We'll use the information provided in this Section to assess risk as we consider this application for reinstatement.

Questions 1 through 12 relate to the Insured. In this Section, "You" and "Your" refer to the Insured.

1. Your height and weight, weight change, if any, and the reason for your weight change.

Height (ft/in)	Weight (lbs)	Weight change (gained or lost in the past 12 mos.)	Reason for the weight change

2. In the last 10 years have you used nicotine (tobacco) in any form? ☐ Yes ☐ No

If **YES**, check tobacco type(s) and indicate date last used *(mm/dd/yyyy)* where noted.

☐ Cigarettes Date last used ____________ ☐ Nicotine substitutes *(e.g., gum, patch, electronic/e-cigarettes)* Date last used ____________

☐ Cigar, Pipe, Cigarillos

☐ Chewing tobacco or snuff ☐ Other ______________________ Date last used ____________

3. Have you ever had an application for life insurance, disability benefits or health insurance declined, postponed, rated, modified or required an extra premium charge; or been denied disability benefits, refused renewal or refused reinstatement? ☐ Yes ☐ No

If **YES**, please describe the actions taken and the reasons for those actions.

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4. Do you plan to travel or reside outside the United States in the next two years? ☐ Yes ☐ No

If **YES**, provide dates, location, purpose of travel, frequency and length of intended stay(s).

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5. Have you been disabled in the last 10 years? ☐ Yes ☐ No

If **YES**, furnish reason(s) with dates and physician's name and address.

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6. In the last 10 years have you been bedridden, unable to work or confined to a hospital, assisted living facility and/or nursing home or received home-based nursing/assisted care? ☐ Yes ☐ No

If **YES**, furnish reason(s) with dates and physician's name and address and hospital, assisted living facility and/or nursing home's name and address.

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7. Have you been convicted of or pled Guilty or No Contest to a felony in the last 10 years? ☐ Yes ☐ No

If **YES**, list type of felony, date of conviction and state/jurisdiction, date of release.

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8. In the last 10 years have you used cocaine, heroin or other illegal drugs or used prescription medications in a manner other than as prescribed? ☐ Yes ☐ No

If **YES**, provide details for each drug used including date last used.

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9. In the last 10 years have you received treatment for, or been recommended to have treatment for, the use of alcohol, or illegal or controlled substances (ex. narcotics, sedatives)? ☐ Yes ☐ No

If **YES**, furnish name and address of treatment facility and date(s).

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10. In the last 10 years have you had your driver's license suspended or revoked due to driving violations, or been convicted of DUI/DWI? ☐ Yes ☐ No

If **YES**, provide date of driver's license suspension/revocation or DUI/DWI conviction and current driver's license number and state of issue.

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11. Have you in the last 10 years been diagnosed, received treatment, consulted with a physician or health professional or has a physician or health professional scheduled or recommended treatment, surgery or any other medical procedure for you for any of the following conditions? ☐ Yes ☐ No

If **YES**, check the appropriate boxes below and provide details in the table. If additional space is needed for your responses, please attach separate piece(s) of paper with the information from the table.

A. ☐ High blood pressure
B. ☐ High cholesterol
C. ☐ Diabetes
D. ☐ Cancer/Tumor/Polyp
E. ☐ Depression/Anxiety
F. ☐ Anemia/Blood disorders
G. ☐ Sleep apnea
H. ☐ Seizures
I. ☐ Arthritis
J. ☐ Paralysis
K. ☐ Multiple sclerosis
L. ☐ Parkinson's disease/ALS
M. ☐ Colitis/Crohn's disease
N. ☐ Cirrhosis
O. ☐ Hepatitis
P. ☐ Systemic lupus (SLE)
Q. ☐ Eating disorders
R. ☐ Psychiatric disorder
S. ☐ Dementia/Memory loss/Alzheimer's disease
T. ☐ Organ Failure/Transplant
U. ☐ Asthma/Bronchitis/Chronic Obstructive Pulmonary Disease (COPD)/Emphysema
V. ☐ Chest pain/Heart attack/Heart murmur
W. ☐ Stroke/Transient Ischemic Attack (TIA)
X. ☐ Human Immunodeficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS)

Letter from above	Date *(mm/dd/yyyy)* of Original Diagnosis/Treatment	Name and address of health care professional	Diagnosis/Treatment/Medications

12. In the last 10 years, have you undergone, or has it been recommended that you undergo, any testing (*e.g.*, blood, urine, x-ray, EKG/ECG or other testing) for any of the following? ☐ Yes ☐ No
If **YES**, check the appropriate boxes below and provide details in the table. If additional space is needed for your responses, please attach separate piece(s) of paper with the information from the table.

A. ☐ Heart
B. ☐ Arteries/Veins
C. ☐ Lungs/Respiratory system
D. ☐ Gastrointestinal/Digestive system
E. ☐ Liver/Pancreas
F. ☐ Kidney/Bladder
G. ☐ Prostate
H. ☐ Reproductive organs/system
I. ☐ Brain/Nervous system
J. ☐ Blood
K. ☐ Lymph nodes
L. ☐ Immune system
M. ☐ Thyroid/Other glands
N. ☐ Eyes/Ears /Nose/ Throat/Skin
O. ☐ Muscles/Bones/Joints
P. ☐ Emotional/ Psychological disorder

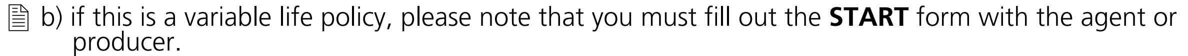
Letter from above	Date *(mm/dd/yyyy)* of Original Diagnosis/Treatment	Name and address of health care professional	Diagnosis/Treatment/Medications

Section 3: Owner Information

1. Have you discussed reinstatement of the Policy with an agent or producer? ☐ Yes ☐ No

If **YES**, a) please provide the name and ID number of the agent or producer.

Agent/Producer name ______________________________ ID number ______________


b) if this is a variable life policy, please note that you must fill out the **START** form with the agent or producer.

2. Please use the space below to provide the name and contact information for the person who should receive any future lapse notices in addition to the Owner. Mailing an additional notice may help to avoid future policy lapses.

First name	Middle name	Last name	Suffix

Address

City	State	ZIP

Primary phone number	Alternate phone number	Email address

3. If the Owner and the Insured are not the same person, please provide the following information about the Owner.

First name	Middle name	Last name	Suffix

Address

City	State	ZIP	Social security number

Primary phone number	Alternate phone number	Email address

Date of birth

Section 4: Agreement

By signing this application in Section 5, I understand and agree to the following statements:

- By signing, I am confirming that the information provided in this document (other than in Section 3(3)) is about the Insured.
- I have reviewed all the information provided in this application to reinstate a life insurance policy, including any supplement(s), and all statements are true and complete to the best of my knowledge and belief.
- **The requested reinstatement will take effect only when and if: this application is approved by the Company; and the Company has received the full amount due.**
- This application and any supplement(s) will become part of the reinstated policy.
- I have received the Company's Consumer Privacy Notice.
- Only the Company's President, Secretary, or a 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, or policy. Any such change must be in writing and signed by the Company's President, Secretary, or a Vice-President.
- If any of the statements or information provided in this application for reinstatement are false or incomplete:
  - a) A claim for benefits under the Policy may be contested for up to two years from the date the Policy was reinstated;

Section 4: Agreement (continued)

b) The Policy may be rescinded and if so, any amounts paid to reinstate the Policy and any subsequent premiums will be returned, and no benefits will be paid to any Beneficiary; and

c) In addition, for residents of Pennsylvania please note the following:

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.

Section 5: Signatures

Signature of Owner if age 15 or older (If the Owner is a firm or corporation, include an officer's title with their signature.)	Date *(mm/dd/yyyy)*	Signed at City, State
Signature of Insured if age 15 or older and other than Owner	Date	Signed at City, State
Signature of Parent or Legal Guardian is required when Owner or Insured is under age 18	Date	Signed at City, State

Page 6 is for information only and is not part of the completed form.

Section 6: How to Submit This Document

Return the first five pages of this form to the MetLife Company listed below.
(The MetLife Company name will appear on the policy lapse letter we mailed you.)

Mail: (along with your check)

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
P.O. Box 371487
Pittsburgh, PA 15250-7487

Fax: (Use only if you have already paid the premium due.)

908-655-9581

Please mail or fax first five pages of this form, fully completed and signed, to avoid delays.

We're here to help

Please don't hesitate to contact us if you have any questions. You can reach us at 800-638-5433, Monday through Friday, 8:00 a.m. to 6:00 p.m. Eastern time.