Important Notice Regarding MetLife's Long-Term Care Inforce Rate Increase History

(Please note the information below replaces the Rate Increase History section of the Long Term Care Insurance Personal Worksheet on the application.)

MetLife has ceased marketing its individual and group Long-Term Care products. Please be advised that with respect to premium rates for existing policyholders, MetLife has raised, or expects to raise, rates on the LTC policy series noted below.

Policy Type	Individual Policy Series*	Years Available	Years Increase Began	Percentage of Increase
Individual LTC	1LTC-97, 2LTC-97	1997 – 2001	2009 2013 2016	0-18% 0-58% 0-102%****
Individual LTC	LTC-VAL, LTC-IDEAL, LTC-PREM, LTC-FAC	2002-2006	2009 2013 2016	0-42% 0-102% 0-126%****
Individual LTC	LTC2-VAL, LTC2-IDEAL, LTC2-PREM, LTC2-FAC	2005-2011	2013 2016	0-88% 0-88%****
Individual LTC	LTC2007	2008-2011	2013 2016	0-58% 0-58%****
Individual LTC	LTC-TIAA-02	1991-2001	2012 2015	0-41% 0-73%****
Individual LTC	LTC-TIAA-03	1992-2003	2012 2015	0-41% 0-73%****
Individual LTC	LTC-TCL-04	2000-2004	2012 2015	0-41% 0-73%****
Group LTC	G.LTC197	1998 – 2003**	2012	0-45%
Group LTC	GPNP99-LTC	2000 – 2010***	2012	0- 45%

*Please note some policy forms may be followed by a state abbreviation or a state abbreviation and the letters "ML."

**While MetLife ceased offering the group policy to group policyholders in the year noted, certificates under the group policy continued to be issued on applications taken through December 31, 2012.

***While MetLife ceased offering the group policy to group policyholders in the year noted, certificates under the group policy continued to be issued on applications taken through December 31, 2012.

****Please note that the percentage of the increase will vary by state, and state filings are in process. Final amounts are subject to any applicable regulatory approvals.

Long-Term Care Insurance

Individual Application & Important Forms

MetLife

For use in the state of
CALIFORNIA

Metropolitan Life Insurance Company
New York, NY 10166

IMPORTANT INSTRUCTIONS FOR AGENTS

- Complete all application pages. Tear out all pages labeled "MAIL THIS PAGE TO METLIFE" and return them to MetLife. Application pages labeled "LEAVE THIS PAGE WITH APPLICANT" stay with applicant.

- All applicants between the ages of 56 - 74 will require a phone health interview. Other applicants may be contacted at the underwriter's discretion. The call is initiated by a Registered Nurse representing MetLife. The interview lasts approximately 20 - 30 minutes, depending on health history. To save time during the interview, please ask your client to have the following available:

  - Current medication bottles
  - Names of physicians
  - Dates of any surgeries or hospitalizations

- Please indicate under *Part D: DETAILS,* the best time to reach your client.
  All applicants between the ages of 75-84 will require a face-to-face interview and assessment. Medical records from the primary physician are required on all applicants age 61 and older or at the underwriter's discretion for age 60 and younger.

- <u>If you are collecting premium payment at time of application:</u>

  You may not collect more than 1 months' premium payment

- The Beneficiary Designation Form for the Return of Premium Rider should only be completed if the Applicant is selecting the Return of Premium Rider and chooses to designate a beneficiary other than their estate.

- Please have applicant review the form titled CA Authorization To Release Information and return if necessary.

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance

A Long-Term Care Insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy thoroughly and make sure you understand what it covers before you purchase.

- You should **not** purchase this policy unless you can afford to pay the premiums every year. Remember that the company may increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare is **not** designed to pay for long-term care.

Medi-Cal

Medi-Cal will generally pay for long-term care services if you have very little income and few assets. If you are now eligible for Medi-Cal, you should not purchase this policy.

- Many people become eligible for Medi-Cal after they have exhausted their own financial resources paying for long-term care services.
- When Medi-Cal pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medi-Cal. To learn more about Medi-Cal, contact your local or state Medi-Cal agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the "Taking Care of Tomorrow A Consumer's Guide to Long Term Care." Read it carefully. If you have decided to apply for Long-Term Care Insurance, you have the right to return the policy within 30 days and receive a full refund of any premium you had paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about Long-Term Care Insurance is available through California's state insurance counseling program. Contact your CA Insurance Department or Department on Aging for more information about the senior health insurance counseling program in your state.

LEAVE THIS PAGE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK.

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

APPLICANT 1 NAME:

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medi-Cal. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Number(s)

The premium for the coverage you are considering will be: $ per month, or $ per year.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program's (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet web site (www.insurance.ca.gov).

TYPE OF POLICY: Guaranteed Renewable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

RATE INCREASE HISTORY: The company has sold long-term care insurance since 1986, and has sold this policy since 2005. MetLife has never increased its rates for long-term care insurance offered by agents to individuals, for long-term care insurance sponsored by employer groups, or for long-term care insurance endorsed by associations. MetLife has only increased its rates for long-term care insurance covering residents of two Continuing Care Retirement Communities (CCRCs). Each increase shown below affected less than 0.6% of MetLife's total long-term care insurance business.

CCRC	Group Policy Form	Years Available	Year(s) of Increase	Percentage of Increase
Community A	#G.9708	1986-97	1995-97	10% each year
Community B	#G.9873	1989-98	1999	9%-38%

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ Family members

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one) ☐ Under $10,000 ☐ $10,000 - $19,999 ☐ $20,000 - $29,999 ☐ $30,000 - $49,999 ☐ Over $50,000

How do you expect your income to change over the next ten years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Have you considered how you will pay for the difference between future costs and your daily benefit amount?

☐ From my Income ☐ From my Savings/Investments ☐ Family members

The national average annual cost of nursing facility care in 2005 was $64,240, but this figure varies across the country. In ten years the national average annual cost would be about $104,640 if costs increase 5% annually.[1]

[1] "MetLife Mature Market Institute. "The MetLife Market Survey of Nursing Home and Home Care Costs," September 2005.

MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET (CONTINUED)

APPLICANT 1

QUESTIONS RELATED TO YOUR INCOME (CONTINUED)

What elimination period are you considering?

Number of days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ Family members

QUESTIONS RELATED TO YOUR SAVING/INVESTMENTS

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

☐ Under $20,000 ☐ $20,000 - $29,999 ☐ $30,000 - $49,999 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing the cost of long-term care services.

DISCLOSURE STATEMENT

APPLICANT 1 If the applicant elects not to disclose any information in the Personal Worksheet, he/she is still required to sign and date below. (check one):

☐ The answers to the questions above describe my financial situation

or

☐ I choose not to disclose this information

☐ **(this box must be checked)** I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

SIGN _____ Date: _____

Signature of Applicant 1

AGENT

☐ I explained to the applicant the importance of completing this information.

SIGN _____ Date: _____

Signature of Authorized Agent

Agent's Printed Name: _____

In order for us to process your application, please return this signed statement to MetLife, along with your application.

IF APPLICABLE

☐ My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

SIGN _____ Date: _____

Signature of Applicant 1

The company may contact you to verify your answers.

SIGN & MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

APPLICANT 2 NAME:

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medi-Cal. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Number(s)

The premium for the coverage you are considering will be: $ per month, or $ per year.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program's (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet web site (www.insurance.ca.gov).

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QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ Family members

☐ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one) ☐ Under $10,000 ☐ $10,000 - $19,999 ☐ $20,000 - $29,999 ☐ $30,000 - $49,999 ☐ Over $50,000

How do you expect your income to change over the next ten years? (check one)

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If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Have you considered how you will pay for the difference between future costs and your daily benefit amount?

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The national average annual cost of nursing facility care in 2005 was $64,240, but this figure varies across the country. In ten years the national average annual cost would be about $104,640 if costs increase 5% annually.[1]

[1] "MetLife Mature Market Institute. "The MetLife Market Survey of Nursing Home and Home Care Costs," September 2005.

MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET (CONTINUED)

APPLICANT 2

QUESTIONS RELATED TO YOUR INCOME (CONTINUED)

What elimination period are you considering?

Number of days _____ Approximate cost $ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

☐ From my Income ☐ From my Savings/Investments ☐ Family members

QUESTIONS RELATED TO YOUR SAVING/INVESTMENTS

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

☐ Under $20,000 ☐ $20,000 - $29,999 ☐ $30,000 - $49,999 ☐ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

☐ No change ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing the cost of long-term care services.

DISCLOSURE STATEMENT

APPLICANT 2 If the applicant elects not to disclose any information in the Personal Worksheet, he/she is still required to sign and date below. (check one):

☐ The answers to the questions above describe my financial situation

or

☐ I choose not to disclose this information

☐ **(this box must be checked)** I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future**.

SIGN _____ Date: _____

Signature of Applicant 2

AGENT

☐ I explained to the applicant the importance of completing this information.

SIGN _____ Date: _____

Signature of Authorized Agent

Agent's Printed Name: _____

In order for us to process your application, please return this signed statement to MetLife, along with your application.

IF APPLICABLE

☐ My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

SIGN _____ Date: _____

Signature of Applicant 2

The company may contact you to verify your answers.

SIGN & MAIL THIS PAGE TO METLIFE

AUTHORIZATION TO PROCEED PROCESSING APPLICATION

APPLICANT 1

If the applicant elects not to complete the Long-Term Care Insurance Personal Worksheet, this form must be completed and submitted with the application and the signed Long-Term Care Insurance Personal Worksheet in order to process the application.

TO: Long-Term Care Division, Metropolitan Life Insurance Company

Re: Financial Suitability of the purchase of Long-Term Care Insurance
I am applying for long-term care insurance. My Agent/Producer has explained to me that my financial situation is an important consideration as to whether or not long-term care insurance is an appropriate purchase for me.

My Agent/Producer has also explained the importance of completing the Long-Term Care Insurance Personal Worksheet. This information can help me determine whether I should purchase long-term care insurance and can afford to pay the required premium.

I hereby confirm that I choose not to complete the financial information on the Long-Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long-term care insurance coverage.

SIGN

Applicant Signature | Date

APPLICANT 2

If the applicant elects not to complete the Long-Term Care Insurance Personal Worksheet, this form must be completed and submitted with the application and the signed Long-Term Care Insurance Personal Worksheet in order to process the application.

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SIGN

Applicant Signature | Date

SIGN & MAIL THIS PAGE TO METLIFE

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Application for Individual Long-Term Care Insurance

AGENT

All pages labeled "MAIL THIS PAGE TO METLIFE", the Authorization and, if a replacement policy, the Replacement Notice must be submitted to:
Metropolitan Life Insurance Company Individual Long-Term Care

Payment Enclosed: $_____

Metropolitan Life Insurance Company
New York, NY 10166

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Metropolitan Life Insurance Company
New York, NY 10166

PART A PERSON(S) APPLYING FOR COVERAGE

THE POLICY IS AN APPROVED LONG-TERM CARE INSURANCE CONTRACT UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THE POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1 (800) 434-0222.

The Contract for Long-Term Care Insurance is intended to be a federally qualified Long-Term Care Insurance contract and may qualify you for federal and state tax benefits.

Please complete ALL information for EACH applicant below.

APPLICANT 1	APPLICANT 2
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)	☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. (check one)
1. _____ First Name Middle Initial	1. _____ First Name Middle Initial
2. _____ Last Name	2. _____ Last Name
3. _____ Address Apt. #	3. _____ Address Apt. #
4. _____ City State Zip	4. _____ City State Zip
5. _____ Home Phone	5. _____ Home Phone
6. _____ Work Phone	6. _____ Work Phone
7. Gender: ☐ Male ☐ Female	7. Gender: ☐ Male ☐ Female

MAIL THIS PAGE TO METLIFE

PART A PERSON(S) APPLYING FOR COVERAGE (CONTINUED)

APPLICANT 1	APPLICANT 2
8. Date of Birth: _____ (MM/DD/YYYY)	8. Date of Birth: _____ (MM/DD/YYYY)
9. Social Security #: _____	9. Social Security #: _____
10. Status: ☐ Single ☐ Married ☐ Domestic Partner* (Please check "Single" if you are widowed or divorced.)	10. Status: ☐ Single ☐ Married ☐ Domestic Partner* (Please check "Single" if you are widowed or divorced.)
11. Is your Spouse or Domestic Partner* applying for coverage? ☐ Yes ☐ No	11. Is your Spouse or Domestic Partner* applying for coverage? ☐ Yes ☐ No
IF "YES" your Spouse's or Domestic Partner's*:	**IF "YES"** your Spouse's or Domestic Partner's*:
12. Name: _____ Social Security #: _____	12. Name: _____ Social Security #: _____
13. Is any other member of your household applying for coverage? ☐ Yes ☐ No	13. Is any other member of your household applying for coverage? ☐ Yes ☐ No
IF "YES"	**IF "YES"**
14. Name: _____ Social Security #: _____	14. Name: _____ Social Security #: _____
15. This is a request for: ☐ Initial Coverage ☐ Increase in Coverage ☐ Re-apply	15. This is a request for: ☐ Initial Coverage ☐ Increase in Coverage ☐ Re-apply

*"Domestic Partner" means each of two people: who have registered or filed as Domestic Partners or members of a civil union with a government agency or office where such registration is available; or who meet the following requirements: each person is 18 years of age or older; neither person is married; they share the same residence; they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and they have an exclusive mutual commitment to share the responsibility to each other's welfare and financial obligations and such commitment is expected to last indefinitely.

MAIL THIS PAGE TO METLIFE

PART B INSURABILITY QUESTIONS

Please answer these questions BEFORE you continue with other parts of this Application.

	APPLICANT 1		APPLICANT 2	
1. Have you had, do you currently have, have you ever been medically diagnosed as having or have you been treated for:	**Yes**	**No**	**Yes**	**No**
a. Alzheimer's disease?	☐	☐	☐	☐
b. Dementia?	☐	☐	☐	☐
c. Frequent or persistent forgetfulness that is progressive or for which you take medication?	☐	☐	☐	☐
d. Mental retardation?	☐	☐	☐	☐
e. Parkinson's disease or syndrome?	☐	☐	☐	☐
f. Multiple sclerosis?	☐	☐	☐	☐
g. Amyotrophic lateral sclerosis (Lou Gehrig's disease)?	☐	☐	☐	☐
h. Muscular dystrophy?	☐	☐	☐	☐
i. Stroke or any other type of cerebral vascular accident (CVA) within the last 5 years?	☐	☐	☐	☐
j. Multiple strokes?	☐	☐	☐	☐
k. Stroke with residual impairment?	☐	☐	☐	☐
l. Transient ischemic attack (TIA) within the last 5 years?	☐	☐	☐	☐
m. Multiple transient ischemic attacks (TIA)?	☐	☐	☐	☐
n. Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐	☐	☐
o. AIDS related complex (ARC)?	☐	☐	☐	☐
p. Immune deficiency disorder (except HIV infection)?	☐	☐	☐	☐
q. Cancer that has spread to another area of your body, including lymph nodes?	☐	☐	☐	☐
r. Cancer treated in past 24 months (except basal cell or squamous cell cancer of the skin or early stage breast or prostate cancer)?	☐	☐	☐	☐
s. Cirrhosis of the liver?	☐	☐	☐	☐
t. Any chronic respiratory disease, in combination with smoking?	☐	☐	☐	☐
u. Congestive heart failure for which you are currently being treated (including treatment by medication)?	☐	☐	☐	☐

MAIL THIS PAGE TO METLIFE

PART B INSURABILITY QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
v. Diabetes with Physician diagnosed complication (except Retinopathy)?	☐	☐	☐	☐
w. Schizophrenia?	☐	☐	☐	☐
x. Any mental or nervous disorder for which you have been hospitalized in the past 2 years?	☐	☐	☐	☐
y. Any mental or nervous disorder for which you have had multiple hospitalizations?	☐	☐	☐	☐
2. Have you had, or do you plan to have, any organ transplant (except corneal transplant)?	☐	☐	☐	☐
3. Do you require human assistance or supervision for any of the following activities:				
a. bathing?	☐	☐	☐	☐
b. dressing?	☐	☐	☐	☐
c. eating?	☐	☐	☐	☐
d. getting in or out of bed or a chair?	☐	☐	☐	☐
e. walking?	☐	☐	☐	☐
f. use of toilet?	☐	☐	☐	☐
g. bowel or bladder control?.	☐	☐	☐	☐
4. Do you currently use a				
a. wheelchair?	☐	☐	☐	☐
b. motorized scooter?	☐	☐	☐	☐
c. walker?	☐	☐	☐	☐
d. quad cane?	☐	☐	☐	☐
e. dialysis?	☐	☐	☐	☐
f. oxygen treatment for respiratory disease or heart disease?	☐	☐	☐	☐
5. Are you currently residing in a Nursing Facility or Residential Care Facility or Residential Care Facility for the elderly?	☐	☐	☐	☐
6. Are you currently receiving home health care services or attending adult day health care?	☐	☐	☐	☐

If you answered "YES" to any part of PART B, questions 1-6, PLEASE DO NOT CONTINUE.
We regret that we cannot offer you Long-Term Care Insurance coverage.

If you answered "NO" to all of PART B, questions 1-6 please CONTINUE...

MAIL THIS PAGE TO METLIFE

PART C COVERAGE SELECTIONS YOU ARE APPLYING FOR

APPLICANT 1	APPLICANT 2
1. Select Your Plan of Coverage: ☐ **Value** ☐ **Ideal** ☐ **Nursing Facility/Residential Care Facility-Only**	**1. Select Your Plan of Coverage:** ☐ **Value** ☐ **Ideal** ☐ **Nursing Facility/Residential Care Facility-Only**
2. Select Your Maximum Nursing Home Daily Benefit Amount ("DBA"): DBA: $ _____ ($90 to $400 per day, in $10 increments) Note: $100 minimum DBA required if selecting the Ideal policy.	**2. Select Your Maximum Nursing Home Daily Benefit Amount ("DBA"):** DBA: $ _____ ($90 to $400 per day, in $10 increments) Note: $100 minimum DBA required if selecting the Ideal policy.
3. Select Your Benefit Period Multiplier: (Your Total Lifetime Benefit = Benefit Period X DBA) ☐ 730 (2-year) ☐ 1,095 (3-year) ☐ 1,460 (4-year) ☐ 1,825 (5-year) ☐ 2,555 (7-year)	**3. Select Your Benefit Period Multiplier:** (Your Total Lifetime Benefit = Benefit Period X DBA) ☐ 730 (2-year) ☐ 1,095 (3-year) ☐ 1,460 (4-year) ☐ 1,825 (5-year) ☐ 2,555 (7-year)
4. Select the percentage of DBA to be paid for Primary Services: *Do not select any of the following if a Nursing Facility/Residential Care Facility-Only Policy is chosen* a. **For Value,** select your Home Care and Residential Care Facility paid at: ☐ 100% ☐ 75% b. **For Ideal,** select your Home Care paid at: ☐ 100% ☐ 75% ☐ 50% ($100 minimum DBA required) *(continued)*	**4. Select the percentage of DBA to be paid for Primary Services:** *Do not select any of the following if a Nursing Facility/Residential Care Facility-Only Policy is chosen* a. **For Value,** select your Home Care and Residential Care Facility paid at: ☐ 100% ☐ 75% b. **For Ideal,** select your Home Care paid at: ☐ 100% ☐ 75% ☐ 50% ($100 minimum DBA required) *(continued)*

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PART C COVERAGE SELECTIONS YOU ARE APPLYING FOR (CONTINUED)

APPLICANT 1	APPLICANT 2
5. Select an Elimination Period: ☐ 20 Days ☐ 45 Days ☐ 100 Days	**5. Select an Elimination Period:** ☐ 20 Days ☐ 45 Days ☐ 100 Days
6. Select Optional Riders: ☐ **Indemnity Rider** (Available with Value policy only) ☐ **Shared Care Rider** Spouse/Domestic Partner must have identical coverage (Not available with Restoration of Benefits Rider) ☐ **Paid-Up Survivorship Rider** ☐ **Calendar Day Rider** (Only available with Value & Ideal policies; Not available with Home Care EP Waiver) ☐ **Home Care EP Waiver** (Only available with Value & Ideal policies; Not available with Calendar Day Rider) ☐ **Restoration of Benefits Rider** (Not available with Shared Care Rider) ☐ **Return of Premium Rider** To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.	**6. Select Optional Riders:** ☐ **Indemnity Rider** (Available with Value policy only) ☐ **Shared Care Rider** Spouse/Domestic Partner must have identical coverage (Not available with Restoration of Benefits Rider) ☐ **Paid-Up Survivorship Rider** ☐ **Calendar Day Rider** (Only available with Value & Ideal policies; Not available with Home Care EP Waiver) ☐ **Home Care EP Waiver** (Only available with Value & Ideal policies; Not available with Calendar Day Rider) ☐ **Restoration of Benefits Rider** (Not available with Shared Care Rider) ☐ **Return of Premium Rider** To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.
7. Benefit Increase Options (choose one): ☐ 5% Automatic Compound Inflation Protection Rider ☐ 5% Automatic Simple Benefit Increase Rider ☐ Future Purchase Rider* ☐ No Inflation Protection Rider * Not available if an Accelerated Premium Payment Rider is selected.	**7. Benefit Increase Options (choose one):** ☐ 5% Automatic Compound Inflation Protection Rider ☐ 5% Automatic Simple Benefit Increase Rider ☐ Future Purchase Rider* ☐ No Inflation Protection Rider * Not available if an Accelerated Premium Payment Rider is selected.
8. Nonforfeiture Coverage Rider: **I Select Nonforfeiture Coverage Rider** ☐ Yes ☐ No	**8. Nonforfeiture Coverage Rider:** **I Select Nonforfeiture Coverage Rider** ☐ Yes ☐ No

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PART D HEALTH QUESTIONS

APPLICANT 1	APPLICANT 2
PRIMARY PHYSICIAN who has most of your medical records: Name: _____ Telephone: (_____)_____ Address: _____ City: _____ State:_____ Zip:_____	**PRIMARY PHYSICIAN who has most of your medical records:** Name: _____ Telephone: (_____)_____ Address: _____ City: _____ State:_____ Zip:_____

	APPLICANT 1		APPLICANT 2	
1. Have you had, do you currently have, have you been medically diagnosed as having or have you been treated for:	**Yes**	**No**	**Yes**	**No**
a. Cancer (except basal cell cancer or squamous cell cancer of the skin)?	☐	☐	☐	☐
b. Heart disease?	☐	☐	☐	☐
c. Congestive heart failure?	☐	☐	☐	☐
d. Arrhythmia?	☐	☐	☐	☐
e. Angina?	☐	☐	☐	☐
f. Heart attack?	☐	☐	☐	☐
g. Heart surgery?	☐	☐	☐	☐
h. Angioplasty?	☐	☐	☐	☐
i. Hypertension?	☐	☐	☐	☐
j. Stroke or any other type of Cerebral Vascular Accident (CVA)?	☐	☐	☐	☐
k. Transient Ischemic Attack (TIA)?	☐	☐	☐	☐
l. Chronic lung disease?	☐	☐	☐	☐
m. Chronic liver disease?	☐	☐	☐	☐
n. Chronic kidney disease?	☐	☐	☐	☐
o. Diabetes – insulin or non-insulin dependent?	☐	☐	☐	☐
p. Chronic neurological disease?	☐	☐	☐	☐
q. Seizure disorder?	☐	☐	☐	☐
r. Condition of the spine or peripheral nerves?	☐	☐	☐	☐
s. Psychiatric disorder?	☐	☐	☐	☐
t. Depression?	☐	☐	☐	☐

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PART D HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
u. Arthritis?	☐	☐	☐	☐
v. Muscle disorder (e.g., fibromyalgia)?	☐	☐	☐	☐
w. Immune system disorder (except HIV infection)?	☐	☐	☐	☐
x. Connective tissue disorder (e.g., Scleroderma)?	☐	☐	☐	☐
y. Lupus erythematosus?	☐	☐	☐	☐
z. Amputation?	☐	☐	☐	☐
aa. Osteoporosis?	☐	☐	☐	☐
bb. Joint replacement?	☐	☐	☐	☐
cc. Fractured hip?	☐	☐	☐	☐
dd. More than one fractured bone in the last 2 years?	☐	☐	☐	☐
ee. Any falls in the last 2 years?	☐	☐	☐	☐
ff. Paralysis?	☐	☐	☐	☐
gg. Weakness of extremities?	☐	☐	☐	☐
hh. Numbness of extremities?	☐	☐	☐	☐
ii. Tremors?	☐	☐	☐	☐
jj. Imbalance?	☐	☐	☐	☐
kk. Gait disturbance?	☐	☐	☐	☐
ll. Dizziness?	☐	☐	☐	☐
mm. Memory loss?	☐	☐	☐	☐
2. Do you currently use any medical equipment (e.g., cane, brace, crutches, or stair lift)?	☐	☐	☐	☐
3. Do you require assistance in activities such as				
a. shopping?	☐	☐	☐	☐
b. managing finances?	☐	☐	☐	☐
c. meal preparation?	☐	☐	☐	☐
d. transportation?	☐	☐	☐	☐
e. laundry?	☐	☐	☐	☐
f. taking your medications?	☐	☐	☐	☐

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PART D HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
4. Are you currently receiving any				
a. disability income?	☐	☐	☐	☐
b. worker's compensation?	☐	☐	☐	☐
c. social security disability income?	☐	☐	☐	☐
d. federal or state disability payments?	☐	☐	☐	☐
5. Have you ever had an application for				
Life Insurance:				
a. declined?	☐	☐	☐	☐
b. postponed?	☐	☐	☐	☐
c. rated less than standard?	☐	☐	☐	☐
Health Insurance:				
d. declined?	☐	☐	☐	☐
e. postponed?	☐	☐	☐	☐
f. rated less than standard?	☐	☐	☐	☐
Long-Term Care Insurance:				
g. declined?	☐	☐	☐	☐
h. postponed?	☐	☐	☐	☐
i. rated less than standard?	☐	☐	☐	☐
6. Have you ever resided in or been advised to enter a				
a. nursing facility?	☐	☐	☐	☐
b. residential care facility?	☐	☐	☐	☐
c. residential care facility for the elderly?	☐	☐	☐	☐
d. retirement community?	☐	☐	☐	☐
7. Have you ever received home health care services or attended adult day health care?	☐	☐	☐	☐
8. In the last 2 years, have you been hospitalized?	☐	☐	☐	☐
9. Have you had any past surgeries, or do you plan to have surgery?	☐	☐	☐	☐
10. Have you been advised to seek medical attention for any symptoms, testing, surgery or treatment?	☐	☐	☐	☐

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PART D HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
11. Have you taken any prescription medications during the past 12 months?	☐	☐	☐	☐

IF "YES" to Part D question 11, please list medications below.
Please use additional paper, if necessary.

APPLICANT 1	APPLICANT 2
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
Medication: _____	Medication: _____
Prescribing Physician:_____	Prescribing Physician:_____
(continued)	*(continued)*

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PART D HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
12. Have you used tobacco products within the last 2 years?	☐	☐	☐	☐
IF "YES" date of last use				
13. Do you currently use alcoholic beverages?	☐	☐	☐	☐
IF "YES" How often?				
How much?				
14. Have you ever been treated, hospitalized or counseled for the use of alcohol or controlled substances?	☐	☐	☐	☐
IF "YES" date of treatment:				
15. What is your height? (in inches)				
16. What is your weight? (in pounds)				

APPLICANT 1

17. Do you:

a. exercise? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

b. drive a motor vehicle? ☐ **Yes** ☐ **No**

IF "YES" how many miles per week? _____

c. work outside the home? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

d. do volunteer work? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

e. have hobbies? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

(continued)

APPLICANT 2

17. Do you:

a. exercise? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

b. drive a motor vehicle? ☐ **Yes** ☐ **No**

IF "YES" how many miles per week? _____

c. work outside the home? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

d. do volunteer work? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

e. have hobbies? ☐ **Yes** ☐ **No**

IF "YES" please describe: _____

_____

_____

(continued)

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PART E HOW YOU WANT TO PAY PREMIUMS

APPLICANT 1

1. Choose only ONE Premium Payment Option:

☐ Standard Mode

ACCELERATED PAYMENT RIDERS:

☐ Double Pay First Year Rider

☐ Reduced Pay at Age 65 Rider

☐ Paid-Up Premiums Rider

☐ Ten Year Premium Payment Rider

2. Choose any ONE of the payment methods and modes below.

Please note that paying insurance premiums more often than annually will cost more than paying them once a year. (e.g.: If premium is $1,000 Annually – selecting Quarterly would increase your Annual premium by $60.)

a. Direct Bill (Select premium mode):

☐ Annually

☐ Semi-Annually (2% more than Annually)

☐ Quarterly (6% more than Annually)

☐ Monthly Automatic Checking Account Deduction (complete Part E, #3) (8% more than Annually)

b. Third-party payer (if applicable): Select premium mode:

☐ Annually

☐ Semi-Annually (2% more than Annually)

☐ Quarterly (6% more than Annually)

FOR A OR B MAIL BILL TO:

Full Name: _____

Address: _____

Apt. # _____ City: _____

State: _____ Zip: _____

Telephone: (_____) _____

(continued)

APPLICANT 2

1. Choose only ONE Premium Payment Option:

☐ Standard Mode

ACCELERATED PAYMENT RIDERS:

☐ Double Pay First Year Rider

☐ Reduced Pay at Age 65 Rider

☐ Paid-Up Premiums Rider

☐ Ten Year Premium Payment Rider

2. Choose any ONE of the payment methods and modes below.

Please note that paying insurance premiums more often than annually will cost more than paying them once a year. (e.g.: If premium is $1,000 Annually – selecting Quarterly would increase your Annual premium by $60.)

a. Direct Bill (Select premium mode):

☐ Annually

☐ Semi-Annually (2% more than Annually)

☐ Quarterly (6% more than Annually)

☐ Monthly Automatic Checking Account Deduction (complete Part E, #3) (8% more than Annually)

b. Third-party payer (if applicable): Select premium mode:

☐ Annually

☐ Semi-Annually (2% more than Annually)

☐ Quarterly (6% more than Annually)

FOR A OR B MAIL BILL TO:

Full Name: _____

Address: _____

Apt. # _____ City: _____

State: _____ Zip: _____

Telephone: (_____) _____

(continued)

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PART E HOW YOU WANT TO PAY PREMIUMS (CONTINUED)

APPLICANT 1

ELECTRONIC PAYMENT AGREEMENT AUTHORIZATION

3. ☐ Automatic Checking Account Deduction (Monthly):

Your monthly premium will be deducted automatically from the bank or credit union checking account you request.

If you are submitting cash with your application you must enclose one months' premium. Enclose a voided blank check for the account you wish to use.

If using a credit union account, please provide credit union phone number.

Phone #: (_____) _____

I authorize: (1) MetLife to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my enclosed sample check (marked VOID) is drawn to: (a) accept the deductions initiated by MetLife; and (b) give MetLife my most recent address upon MetLife's request. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

SIGN

_____
Signature of Account Holder for Monthly Automatic Deductions

_____
Date

APPLICANT 2

ELECTRONIC PAYMENT AGREEMENT AUTHORIZATION

3. ☐ Automatic Checking Account Deduction (Monthly):

Your monthly premium will be deducted automatically from the bank or credit union checking account you request.

If you are submitting cash with your application you must enclose one months' premium. Enclose a voided blank check for the account you wish to use.

If using a credit union account, please provide credit union phone number.

Phone #: (_____) _____

I authorize: (1) MetLife to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my enclosed sample check (marked VOID) is drawn to: (a) accept the deductions initiated by MetLife; and (b) give MetLife my most recent address upon MetLife's request. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service. I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

SIGN

_____
Signature of Account Holder for Monthly Automatic Deductions

_____
Date

SIGN & MAIL THIS PAGE TO METLIFE

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PART F REPLACEMENT QUESTIONS

You MUST answer all questions or We will not be able to process this application.
State regulations require that We ask the following questions if you are applying for insurance.

APPLICANT 1	APPLICANT 2
1. Do you have another Long-Term Care Insurance policy or certificate in-force (including a health care service contract or a health maintenance organization contract)? ☐ **Yes** ☐ **No** **IF "YES"** the types and amounts of coverage? _____ _____	**1.** Do you have another Long-Term Care Insurance policy or certificate in-force (including a health care service contract or a health maintenance organization contract)? ☐ **Yes** ☐ **No** **IF "YES"** the types and amounts of coverage? _____ _____
2. Did you have another Long-Term Care Insurance policy or certificate in-force during the last twelve (12) months? ☐ **Yes** ☐ **No** **IF "YES"** with which insurance company? _____ _____ If that policy or certificate lapsed, when did it lapse? _____ _____ Is the policy in-force under a nonforfeiture benefit provision? ☐ **Yes** ☐ **No**	**2.** Did you have another Long-Term Care Insurance policy or certificate in-force during the last twelve (12) months? ☐ **Yes** ☐ **No** **IF "YES"** with which insurance company? _____ _____ If that policy or certificate lapsed, when did it lapse? _____ _____ Is the policy in-force under a nonforfeiture benefit provision? ☐ **Yes** ☐ **No**
3. Are you covered under Medi-Cal? ("Medi-Cal" is different from "Medicare.") ☐ **Yes** ☐ **No**	**3.** Are you covered under Medi-Cal? ("Medi-Cal" is different from "Medicare.") ☐ **Yes** ☐ **No**
4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? ☐ **Yes** ☐ **No** **IF "YES"** please complete all information below **and** sign Replacement Notice in back of application: Policy #:_____ Insurance Company Name:_____ Insurance Company Address: _____ _____ _____	**4.** Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? ☐ **Yes** ☐ **No** **IF "YES"** please complete all information below **and** sign Replacement Notice in back of application: Policy #:_____ Insurance Company Name:_____ Insurance Company Address: _____ _____ _____

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PART G AGREEMENT AND ACKNOWLEDGEMENT

APPLICANT 1

REQUIRED INFORMATION

Please check to indicate that the Agent has delivered the following items:

- ☐ Outline of Coverage for the policy applied for, which includes a graphic comparison of a policy with and without the 5% Automatic Compound Inflation Protection Rider
- ☐ Taking Care of Tomorrow (Shopper's Guide to Long-Term Care)
- ☐ If this is a replacement policy, Replacement Notice
- ☐ MetLife's Consumer Privacy Notice
- ☐ HICAP Notice
- ☐ Long-Term Care Insurance Personal Worksheet
- ☐ Information, including address and phone number of local HICAP office
- ☐ Guide to Health Insurance for People with Medicare (if eligible for Medicare)

SIGN _____
Signature of Applicant 1

_____
Date

I have delivered all of the above documents to the Applicant.

SIGN _____
Signature of Licensed and Appointed Agent

_____
Date

(continued)

APPLICANT 2

REQUIRED INFORMATION

Please check to indicate that the Agent has delivered the following items:

- ☐ Outline of Coverage for the policy applied for, which includes a graphic comparison of a policy with and without the 5% Automatic Compound Inflation Protection Rider
- ☐ Taking Care of Tomorrow (Shopper's Guide to Long-Term Care)
- ☐ If this is a replacement policy, Replacement Notice
- ☐ MetLife's Consumer Privacy Notice
- ☐ HICAP Notice
- ☐ Long-Term Care Insurance Personal Worksheet
- ☐ Information, including address and phone number of local HICAP office
- ☐ Guide to Health Insurance for People with Medicare (if eligible for Medicare)

SIGN _____
Signature of Applicant 2

_____
Date

I have delivered all of the above documents to the Applicant.

SIGN _____
Signature of Licensed and Appointed Agent

_____
Date

(continued)

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PART G AGREEMENT AND ACKNOWLEDGEMENT (CONTINUED)

APPLICANT 1

1. Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: _____

Relationship: _____

Address: _____

Apt.# _____ Telephone: (____) _____

City: _____

State: _____ Zip: _____

☐ I elect NOT to designate any person to receive the notice.

Rejection of Compound Inflation Protection

☐ I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed options for Compound increase, and I reject the 5% Automatic Compound Inflation Protection Rider.

Rejection of Nonforfeiture

☐ I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider.

(continued)

APPLICANT 2

1. Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Full Name: _____

Relationship: _____

Address: _____

Apt.# _____ Telephone: (____) _____

City: _____

State: _____ Zip: _____

☐ I elect NOT to designate any person to receive the notice.

Rejection of Compound Inflation Protection

☐ I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed options for Compound increase, and I reject the 5% Automatic Compound Inflation Protection Rider.

Rejection of Nonforfeiture

☐ I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider.

(continued)

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PART G AGREEMENT AND ACKNOWLEDGEMENT (CONTINUED)

APPLICANT 1

I understand that if this is an application for a new policy (Initial Coverage), then except as stated in the Conditional Premium Receipt, MetLife will have no liability until a policy is personally delivered to me and the full first premium is paid.

The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no Conditional Premium Receipt has been issued, or (2) any coverage change that I am applying for; will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is delivered to me; or (2) the date on which any coverage change is scheduled to go into effect.

Wherever my Initials appear in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

Your signature below confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected Automatic Inflation Protection, confirms your review of the information above concerning Automatic Inflation Protection and your rejection of Automatic Inflation Protection.

Caution: *If your answers or statements on this application are misstated or untrue, MetLife may have the right to deny benefits or rescind your coverage.*

Fraud Warning: 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 subjects such person to criminal and civil penalties.

I have read the above answers and statements on this Application. I declare all information supplied in this application is true and complete.

_____
Signature of Applicant 1

_____
Date Signed at City, State

_____
Signature of Licensed and Appointed Agent

_____
Date Signed at City, State

APPLICANT 2

I understand that if this is an application for a new policy (Initial Coverage), then except as stated in the Conditional Premium Receipt, MetLife will have no liability until a policy is personally delivered to me and the full first premium is paid.

The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change then the coverage change will take effect on the effective date of the change.

I understand that: (1) the policy, if no Conditional Premium Receipt has been issued, or (2) any coverage change that I am applying for; will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is delivered to me; or (2) the date on which any coverage change is scheduled to go into effect.

Wherever my Initials appear in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

Your signature below confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected Automatic Inflation Protection, confirms your review of the information above concerning Automatic Inflation Protection and your rejection of Automatic Inflation Protection.

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I have read the above answers and statements on this Application. I declare all information supplied in this application is true and complete.

_____
Signature of Applicant 2

_____
Date Signed at City, State

_____
Signature of Licensed and Appointed Agent

_____
Date Signed at City, State

SIGN & MAIL THIS PAGE TO METLIFE

AGENT'S REPORT

PLEASE PROVIDE COMPLETE DETAILS TO ENSURE AGAINST DELAYS IN PROCESSING THIS APPLICATION.

APPLICANT 1	APPLICANT 2
1. Did you personally interview the Applicant face to face and witness his or her signature? ☐ **Yes** ☐ **No** **IF "NO"** give details:_____	**1.** Did you personally interview the Applicant face to face and witness his or her signature? ☐ **Yes** ☐ **No** **IF "NO"** give details:_____
2. If you answered "yes" to question 1, did you observe any physical or mental impairments with regard to the Applicant's walking or talking, or any form of tremor? ☐ **Yes** ☐ **No** **IF "YES"** please describe: _____	**2.** If you answered "yes" to question 1, did you observe any physical or mental impairments with regard to the Applicant's walking or talking, or any form of tremor? ☐ **Yes** ☐ **No** **IF "YES"** please describe: _____
3. Please list other health insurance policies sold by you to the Applicant that are still in-force:	**3.** Please list other health insurance policies sold by you to the Applicant that are still in-force:
4. List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force:	**4.** List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force:
5. UNDERWRITING: I have reviewed the underwriting guidelines and the information provided in this application. The following risk class was quoted to the Applicant: ☐ Preferred ☐ Standard	**5. UNDERWRITING**: I have reviewed the underwriting guidelines and the information provided in this application. The following risk class was quoted to the Applicant: ☐ Preferred ☐ Standard
6. APS ordered? ☐ **Yes** ☐ **No** Physician Name: Date Ordered: (MM/DD/YY) Vendor Used:	**6.** APS ordered? ☐ **Yes** ☐ **No** Physician Name: Date Ordered: (MM/DD/YY) Vendor Used:
7. Is this a replacement policy? (If yes, provide Replacement Notice) ☐ **Yes** ☐ **No**	**7.** Is this a replacement policy? (If yes, provide Replacement Notice) ☐ **Yes** ☐ **No**
8. Modal Premium $ Annualized Premium $ *(continued)*	**8.** Modal Premium $ Annualized Premium $ *(continued)*

MAIL THIS PAGE TO METLIFE

9. CERTIFICATION:

☐ I certify that each applicable question was personally asked of the Applicant(s) by me and that I have accurately recorded the information supplied by the Applicant(s). The Applicant(s) was (were) interviewed by me in person or by telephone and all answers on this application are correct and complete to the best of my knowledge and belief. I certify that any required written disclosure statement was given to the Applicant(s) no later than the date this application was signed.

☐ I did not personally interview, by phone or face-to-face, the Applicant(s). I certify that any required written disclosure statement was given to the Applicant(s) no later than the date this application was signed.

SIGN _____ Signature of Licensed & Appointed Agent

_____ Name of Licensed & Appointed Agent (Please Print)

Offered through:* ☐ MLFS ☐ GenAm ☐ MLR ☐ General Agent (other than GenAm) ☐ Other _____ Firm Name

Office ID#_____ Producer #_____ SS#_____

Street Address_____ Apt. #_____ City/State/Zip_____

Phone/Fax_____ e-mail address _____

10. For **split commission cases**, provide the information requested below, indicating the percentage of commission applicable to each:

	Print Name	Agency#/ Firm Name	Producer #	SS#	Percent	Distribution Channel *
1st Rep.						☐ MLFS ☐ GenAm ☐ MLR ☐ General Agent ☐ Other
2nd Rep.						☐ MLFS ☐ GenAm ☐ MLR ☐ General Agent ☐ Other
3rd Rep.						☐ MLFS ☐ GenAm ☐ MLR ☐ General Agent ☐ Other

*Please select the appropriate box based on the distribution channel you are submitting business under:

MLFS....MetLife Financial Services **GenAm**....General American
MLR....MetLife Resources **General Agent**....LTC Brokerage **Other**: _____

YOU MUST COMPLETE THIS SECTION IF YOU ARE SUBMITTING BUSINESS THROUGH LTC BROKERAGE.

MGA Name_____MGA Code_____ MGA Address _____

MGA Phone #_____Fax # _____ _____

MGA contact (for application status)_____ e-mail (for application status) _____

BROKER HIERARCHY: Please list GA1 and AGA name/s and code/s if the broker does not roll up directly to the MGA.

AGA _____
GA1 _____
Broker _____

IF SPLIT

AGA _____
GA1 _____
Broker _____

Enter "pending" if code not yet assigned.

SIGN & MAIL THIS PAGE TO METLIFE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

CONDITIONAL PREMIUM RECEIPT

APPLICANT 1

Received from _____
Name of Applicant 1 (Please print)

$ _____ on _____
Amount Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS CONDITIONAL PREMIUM RECEIPT UNTIL METLIFE APPROVES THE APPLICATION.

It is understood and agreed that payment of the premium shown above under this Conditional Premium Receipt is made and accepted subject to the following conditions:

1. If, after We (Metropolitan Life Insurance Company ("MetLife")) receive: (a) the Initial Application Requirements, as defined below; and (b) evidence of insurability acceptable to Us, We determine that as of the date of the application, you are insurable based upon Our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect. **In the event that all of the conditions in the preceding sentence are satisfied, coverage under this Conditional Receipt will take effect on the Application Date and the coverage shall be governed by the terms and conditions of the policy applied for in the Application.** Any changes in your health after the date of this Receipt will not affect Our underwriting decision.
2. If We issue a policy to you, any unpaid balance of the first full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

For purposes of this Receipt, the Initial Application Requirements are:

1. Completion of the application, in which you have answered "No" to all Questions in Part B of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by Us.
3. Receipt by Us of any Attending Physician Statement(s), medical records and any other medical documents that We may require.
4. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all Questions in Part B of the application are relied upon to accept payment and issue this Receipt. If any of these answers are incomplete or incorrect, or MetLife is unable to approve the application within 60 days from the date of the application, the amount paid will be returned and this Receipt will be null and void from the beginning.

If We determine that as of the date of the application you are not eligible for the insurance coverage applied for, coverage under this Receipt will not become effective. There will be no coverage under the Conditional Premium Receipt and the amount paid will be returned to you.

Limitations on Authority: No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Conditional Premium Receipt. No agent, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of Our requirements.

SIGN & MAIL THIS PAGE TO METLIFE

APPLICANT 1

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of the application. I represent that the answers to all those Questions are true and complete. I understand and agree that if the answers to any of the Questions in Part B of the application are not true and complete, the amount tendered will be returned and this Conditional Premium Receipt will be null and void from the beginning. I understand and agree to all of the terms of this Conditional Premium Receipt. I have received a copy of this Conditional Premium Receipt.

SIGN _____ _____

Signature of Applicant 1 Date

No agent or financial services representative is authorized to accept any payment with the application if you answered "Yes" (or left blank) to any of the Questions in Part B of your application.

Receipt of $ _____ is acknowledged from _____

in connection with the application for Long-Term Care Insurance on this date _____ By:

SIGN _____

Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Gwenn L. Carr

Vice-President and Secretary

MetLife makes no representations as to the tax consequences of premium paid under this Receipt or the Benefits you receive under this Receipt. Consult your own legal or tax advisor.

ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

SIGN & MAIL THIS PAGE TO METLIFE

APPLICANT 1

Received from _____
Name of Applicant 1 (Please print)

$ _____ on _____
Amount Date

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3. Receipt by Us of any Attending Physician Statement(s), medical records and any other medical documents that We may require.
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SIGN & LEAVE THIS PAGE WITH APPLICANT

APPLICANT 1

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SIGN _____ _____

Signature of Applicant 1 Date

No agent or financial services representative is authorized to accept any payment with the application if you answered "Yes" (or left blank) to any of the Questions in Part B of your application.

Receipt of $ _____ is acknowledged from _____

in connection with the application for Long-Term Care Insurance on this date _____ By:

SIGN _____

Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Gwenn L. Carr

Vice-President and Secretary

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SIGN & LEAVE THIS PAGE WITH APPLICANT

CONDITIONAL PREMIUM RECEIPT

APPLICANT 2

Received from _____
Name of Applicant 2 (Please print)

$ _____ on _____
Amount Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS CONDITIONAL PREMIUM RECEIPT UNTIL METLIFE APPROVES THE APPLICATION.

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CONDITIONAL PREMIUM RECEIPT

APPLICANT 2

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SIGN _____ _____

Signature of Applicant 2 Date

No agent or financial services representative is authorized to accept any payment with the application if you answered "Yes" (or left blank) to any of the Questions in Part B of your application.

Receipt of $ _____ is acknowledged from _____

in connection with the application for Long-Term Care Insurance on this date _____ By:

SIGN _____

Signature of Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Vice-President and Secretary

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SIGN & MAIL THIS PAGE TO METLIFE

APPLICANT 2

Received from _____
Name of Applicant 2 (Please print)

$ _____ on _____
Amount Date

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SIGN & LEAVE THIS PAGE WITH APPLICANT

APPLICANT 2

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of the application. I represent that the answers to all those Questions are true and complete. I understand and agree that if the answers to any of the Questions in Part B of the application are not true and complete, the amount tendered will be returned and this Conditional Premium Receipt will be null and void from the beginning. I understand and agree to all of the terms of this Conditional Premium Receipt. I have received a copy of this Conditional Premium Receipt.

SIGN _____ _____

Signature of Applicant 2 Date

No agent or financial services representative is authorized to accept any payment with the application if you answered "Yes" (or left blank) to any of the Questions in Part B of your application.

Receipt of $ _____ is acknowledged from _____

in connection with the application for Long-Term Care Insurance on this date _____ By:

SIGN _____

Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Gwenn L. Carr
Vice-President and Secretary

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SIGN & LEAVE THIS PAGE WITH APPLICANT

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 1

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize any medical practitioner or facility or related entity; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:

- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than 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. I understand that, unless permitted by applicable law, I 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 my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 64911, St. Paul, MN 55164-0911 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

Applicant 1 Name (print) _____ Date of Birth _____

Signature of Applicant 1 _____ Date _____

SIGN & MAIL THIS PAGE TO METLIFE

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 2

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize any medical practitioner or facility or related entity; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:

- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

SIGN

Applicant 2 Name (print) _____ Date of Birth _____

Signature of Applicant 2 _____ Date _____

SIGN & MAIL THIS PAGE TO METLIFE

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 1

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In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize any medical practitioner or facility or related entity; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:

- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
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- information, records and data about me relating to mental illness, other than psychotherapy notes.

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- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

SIGN

Applicant 1 Name (print) _____ Date of Birth _____

Signature of Applicant 1 _____ Date _____

SIGN & LEAVE THIS PAGE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK.

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 2

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- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than 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. I understand that, unless permitted by applicable law, I 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 my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 64911, St. Paul, MN 55164-0911 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

SIGN

Applicant 2 Name (print)	Date of Birth
Signature of Applicant 2	Date

SIGN & LEAVE THIS PAGE WITH APPLICANT

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CALIFORNIA AUTHORIZATION TO RELEASE INFORMATION

APPLICANT 1

Under California law, if your application is denied or if coverage is issued at less than our best rate on the basis of medical record information (other than mental health record information), you may choose to have such information released directly to you or to a medical professional.* If you would like MetLife to send this information directly to you please provide your signature below. At time of decision you will receive the specific health information that was the basis for the decision, along with an “Information Rights Flyer”.

If you would prefer that MetLife send specific medical record information to your physician do not sign below. You will be asked to provide us with the physician’s name you wish to receive the information that was the basis for the decision in the event your application is denied or that coverage is issued at a premium rate other than the company’s best rate. You will also receive instructions how to proceed, along with an "Information Rights Flyer".

* The release of mental health record information directly to you is, under California law, subject to the prior approval of the qualified professional person with treatment responsibility for the condition to which the information relates.

☐ I authorize MetLife to disclose my health information directly to me.

_____ _____

Signature of Applicant 1 Date

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Signature of Applicant 1 Date

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CALIFORNIA AUTHORIZATION TO RELEASE INFORMATION

APPLICANT 2

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Signature of Applicant 2 Date

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_____ _____

Signature of Applicant 2 Date

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CONSUMER PRIVACY NOTICE

APPLICANT 1

Metropolitan Life Insurance Company

If you submit a request for insurance (application or enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company (MetLife).

Please Read This Privacy Notice Carefully. It describes how we learn about you and how we treat the information we collect about you. (If anyone else is to be insured under the coverage you request, what we say here also applies to information about them.)

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our **"affiliates"**) or with other companies.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, health care providers and others. The Authorization that you sign when you applied for insurance permits these sources to tell us about you. So we may, for instance, 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

How We Protect What We Know: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Tell a group customer about its members' claims or cooperating in a group customer's audit of our service

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for

LEAVE THIS PAGE WITH APPLICANT

APPLICANT 1

- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy

Generally, we will disclose only the information we consider reasonably necessary to disclose.

How We Use and Disclose What We Know About You to Offer You Other Products and Services:

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") PROTECTS YOUR INFORMATION IF YOU REQUEST OR PURCHASE LONG-TERM CARE INSURANCE FROM US. IN ADDITION TO THE LIMITATIONS DESCRIBED IN THIS SECTION **"HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU TO OFFER YOU OTHER PRODUCTS AND SERVICES,"** HIPAA FURTHER LIMITS OUR ABILITY TO USE AND DISCLOSE THE INFORMATION THAT WE OBTAIN AS A RESULT OF YOUR REQUEST OR PURCHASE OF LONG-TERM CARE INSURANCE. INFORMATION ABOUT YOUR RIGHTS UNDER HIPAA WILL BE PROVIDED TO YOU WITH ANY LONG-TERM CARE COVERAGE ISSUED TO YOU. FOR MORE INFORMATION SEE THE LAST PARAGRAPH OF THIS NOTICE.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information):

- to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.
- to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you.
- to other financial services companies, if we have joint marketing agreements with them so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company.

You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: This is a general description of MetLife's information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. For example, individuals who request or purchase Long-Term Care Insurance coverage from us have rights under HIPAA. For additional information about your rights under HIPAA, or, for other information about privacy please contact us at our website, www.metlife.com, or write to MetLife, P.O. Box 64911, St. Paul, MN 55164-0911.

Metropolitan Life Insurance Company
New York, NY 10166

LEAVE THIS PAGE WITH APPLICANT

CONSUMER PRIVACY NOTICE

APPLICANT 2

Metropolitan Life Insurance Company

If you submit a request for insurance (application or enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company (MetLife).

Please Read This Privacy Notice Carefully. It describes how we learn about you and how we treat the information we collect about you. (If anyone else is to be insured under the coverage you request, what we say here also applies to information about them.)

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our **"affiliates"**) or with other companies.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, health care providers and others. The Authorization that you sign when you applied for insurance permits these sources to tell us about you. So we may, for instance, 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

How We Protect What We Know: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Tell a group customer about its members' claims or cooperating in a group customer's audit of our service

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for

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APPLICANT 2

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- to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.
- to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you.
- to other financial services companies, if we have joint marketing agreements with them so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company.

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You Can Get Other Material from Us: This is a general description of MetLife's information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. For example, individuals who request or purchase Long-Term Care Insurance coverage from us have rights under HIPAA. For additional information about your rights under HIPAA, or, for other information about privacy please contact us at our website, www.metlife.com, or write to MetLife, P.O. Box 64911, St. Paul, MN 55164-0911.

Metropolitan Life Insurance Company
New York, NY 10166

LEAVE THIS PAGE WITH APPLICANT

Complete this page for REPLACEMENT POLICIES only

APPLICANT 1

*If Part F, question #4 is answered **YES**, complete this Notice and leave a copy with the Applicant.*

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE (LTC) INSURANCE. SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance or Long-Term Care Insurance coverage and replace it with an individual Long-Term Care Insurance policy issued by Metropolitan Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or Long-Term Care Insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this Long-Term Care Insurance coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT: (Use additional sheets as necessary.) I have reviewed your current medical, health, and LTC insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which you may presently have are fully and immediately covered under the new policy, if such policy is issued.
2. In many states, state law provides that your replacement policy may not contain new pre-existing conditions or probationary periods. The policy you are applying for has no such pre-existing conditions or probationary periods.
3. Since you are planning to replace medical, health, or LTC insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after you have thought about it, you still wish to terminate your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

SIGN _____
Signature of Sales Representative, Agent or Broker

_____
Print Name and Address of Sales Representative, Agent or Broker

_____
The above "Notice to Applicant" was delivered to me on: Date

SIGN _____
Signature of Applicant 1

SIGN & LEAVE THIS PAGE WITH APPLICANT

AGENT DETACH HERE

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APPLICANT 1

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Signature of Sales Representative, Agent or Broker

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Print Name and Address of Sales Representative, Agent or Broker

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Signature of Applicant 1

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Complete this page for REPLACEMENT POLICIES only

APPLICANT 2

*If Part F, question #4 is answered **YES**, complete this Notice and leave a copy with the Applicant.*

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Signature of Sales Representative, Agent or Broker

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Print Name and Address of Sales Representative, Agent or Broker

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Signature of Applicant 2

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APPLICANT 2

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Signature of Sales Representative, Agent or Broker

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Print Name and Address of Sales Representative, Agent or Broker

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SIGN _____
Signature of Applicant 2

SIGN & MAIL THIS PAGE TO METLIFE

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LTC BENEFICIARY DESIGNATION FORM FOR RETURN OF PREMIUM RIDER

APPLICANT 1

This form needs to be completed if you want to designate a beneficiary. If you do not want to designate a beneficiary, you do not need to complete this form and MetLife will return premiums under the Return of Premium Rider ("Rider") to your estate in the event of your death. Selecting a beneficiary may have tax implications for you or your beneficiary. Please consult your Tax Advisor for any tax implications of your beneficiary designation for the Rider.

IMPORTANT NOTE: If the beneficiary(ies) you designate is a minor at the time of your death, the amount payable to such beneficiary(ies) shall be made to your estate rather than to that beneficiary(ies).

Applicant Name: _____ Applicant Social Security No.: _____

Please make sure to **check only one** of the following three boxes and complete any necessary accompanying information.

☐ **Individual Beneficiary(ies)**

I name the following Revocable Beneficiary(ies) to receive any amount payable under the policy in the event of my death:

BENEFICIARY DESIGNATION

Full Name (Last, First, Middle Initial)	Relationship	Social Security Number	Date of Birth	Address (Street, City, State, Zip)	Telephone Number	Share %
					TOTAL:	100%

(continued)

MAIL THIS FORM TO METLIFE

LTC BENEFICIARY DESIGNATION FORM (CONTINUED)

APPLICANT 1

If no beneficiary designated shall be living following the insured's death or is otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary shall be paid to the insured's estate. If more than one beneficiary is selected, and one or more, but not all of such beneficiaries are deceased at the time of the insured's death or otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary(ies) shall be paid to the insured's estate.

☐ **Trust(ee) Designation (applies only if a trust has been created in an executed trust agreement)**

Name of Trustee(s) _____

Address _____ **City** _____ **State** ____ **Zip Code** _____

and successor(s) in trust, as Trustee(s) under _____

("Title of the Trust Agreement")

Dated _____ **and executed by me and said Trustee(s).**

If MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the time of the insured's death, I hereby designate my estate as beneficiary.

☐ **Trust(ee) (Under Will) Designation (applies only if a trust has been set forth in your Will)**
The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate my estate as beneficiary.

I understand and agree that any payment made in good faith by MetLife to the legal representative of my estate, pursuant to my designation of a beneficiary choice on this form shall be full discharge of the liability of MetLife with respect to the Return of Premium Rider under the Policy. Further I understand that the refund of premiums on death is not assignable, cannot be pledged or used as collateral for a loan etc; and any beneficiary designation I make is revocable by me prior to my death, but only by completing a MetLife "Beneficiary Designation Change Request Form" available by calling our Customer Service line at (888) 565-3761.

_____
Print Name

SIGN

_____ _____
Signature Date

SIGN & MAIL THIS FORM TO METLIFE

LTC BENEFICIARY DESIGNATION FORM FOR RETURN OF PREMIUM RIDER

APPLICANT 2

This form needs to be completed if you want to designate a beneficiary. If you do not want to designate a beneficiary, you do not need to complete this form and MetLife will return premiums under the Return of Premium Rider ("Rider") to your estate in the event of your death. Selecting a beneficiary may have tax implications for you or your beneficiary. Please consult your Tax Advisor for any tax implications of your beneficiary designation for the Rider.

IMPORTANT NOTE: If the beneficiary(ies) you designate is a minor at the time of your death, the amount payable to such beneficiary(ies) shall be made to your estate rather than to that beneficiary(ies).

Applicant Name: _____ Applicant Social Security No.: _____

Please make sure to **check only one** of the following three boxes and complete any necessary accompanying information.

☐ **Individual Beneficiary(ies)**

I name the following Revocable Beneficiary(ies) to receive any amount payable under the policy in the event of my death:

BENEFICIARY DESIGNATION

Full Name (Last, First, Middle Initial)	Relationship	Social Security Number	Date of Birth	Address (Street, City, State, Zip)	Telephone Number	Share %
					TOTAL:	100%

(continued)

MAIL THIS FORM TO METLIFE

LTC BENEFICIARY DESIGNATION FORM (CONTINUED)

APPLICANT 2

If no beneficiary designated shall be living following the insured's death or is otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary shall be paid to the insured's estate. If more than one beneficiary is selected, and one or more, but not all of such beneficiaries are deceased at the time of the insured's death or otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary(ies) shall be paid to the insured's estate.

☐ **Trust(ee) Designation (applies only if a trust has been created in an executed trust agreement)**

Name of Trustee(s) _____

Address _____ **City** _____ **State** ____ **Zip Code** _____

and successor(s) in trust, as Trustee(s) under _____

("Title of the Trust Agreement")

Dated _____ **and executed by me and said Trustee(s).**

If MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the time of the insured's death, I hereby designate my estate as beneficiary.

☐ **Trust(ee) (Under Will) Designation (applies only if a trust has been set forth in your Will)**
The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate my estate as beneficiary.

I understand and agree that any payment made in good faith by MetLife to the legal representative of my estate, pursuant to my designation of a beneficiary choice on this form shall be full discharge of the liability of MetLife with respect to the Return of Premium Rider under the Policy. Further I understand that the refund of premiums on death is not assignable, cannot be pledged or used as collateral for a loan etc; and any beneficiary designation I make is revocable by me prior to my death, but only by completing a MetLife "Beneficiary Designation Change Request Form" available by calling our Customer Service line at (888) 565-3761.

_____
Print Name

SIGN

_____ _____
Signature Date

SIGN & MAIL THIS FORM TO METLIFE

LONG-TERM CARE INSURANCE REPLACEMENT CHECKLIST

APPLICANT 1

COMPLETE FOR REPLACEMENTS INVOLVING METLIFE LONG-TERM CARE INSURANCE

To be completed by Producer & Submitted with Application

Features:	Existing Policy: Company:	Proposed Replacement MetLife Individual Business	Score
1. Nursing Facility or Comprehensive or Home Health Care			
2. Home Health Care Percent of Nursing Facility Daily Benefit Amount (DBA)			
3. Policy Duration			
4. Inflation Protection			
TOTAL SCORE			

CHECK ONE:

☐ **• IF VALUE OF SCORE IS A POSITIVE NUMBER (+), then the benefits of the MetLife Replacement Policy may be considered Better or Greater than the benefits of the Existing Policy**

☐ **• If Value of score is ZERO (0) or is a NEGATIVE NUMBER (-), then the benefits of the MetLife Replacement Policy may not be considered Better or Greater than the benefits of the Existing Policy.**

To be completed by Applicant:

I have reviewed this form with my producer.

_____
Signature of Applicant

_____
Name of Applicant (Please Print)

_____
Street Address

_____
City

_____
State Zip

To be completed by Licensed and Appointed Producer: I certify that each question was asked of the applicant and answered as recorded.

_____
Signature of Licensed and Appointed Producer

_____
Name of Licensed and Appointed Producer (Please Print)

_____
Phone Fax

_____
Street Address

_____
City

_____
State Zip

(over please)

MAIL THIS FORM TO METLIFE

APPLICANT 1

REPLACEMENT CHECKLIST

Instructions for Comparison & Scoring:

Complete All Questions – Respond on Page 48, Total Score, Complete Applicant & Producer Information, Return Form with Application.

1. **Indicate the Policy Coverages: Home Health Care OR Nursing Facility OR Comprehensive (Both Nursing Facility & Home Health Care)**

   Score: Comprehensive is GREATER than Nursing Home which is GREATER than Home Health Care

   - If MetLife's Coverage is > Existing Policy Coverage,----------then score = **+1**
   - If MetLife's Coverage is = Existing Policy Coverage,----------then score = **0**
   - If MetLife's Coverage is < Existing Policy Coverage,----------then score = **-1**

   If both policies provide comprehensive coverage, then complete #2, if not, skip to #3.

2. **Home Health Care Percentage (HHC%) – Indicate Amount of Home Health Care as a *percentage* of Nursing Facility Daily Benefit Amount (DBA)**

   Score: HIGHER percentage provides more coverage

   - If MetLife's Policy HHC% is > Existing Policy Coverage HHC%,----------then score = **+1**
   - If MetLife's Policy HHC% home care DBA is = Existing Policy Coverage HHC%,-----then score = **0**
   - If MetLife's Policy HHC% home care DBA is < Existing Policy Coverage HHC%,-----then score = **-1**

3. **Total Lifetime Duration – Indicate total policy duration: *Number of years (e.g., 2 years, 3 years, etc.)***

   Score: A LONGER duration provides more coverage

   - If MetLife's Policy Duration is > Existing Policy Duration,----------then score = **+1**
   - If MetLife's Policy Duration is = Existing Policy Duration,----------then score = **0**
   - If MetLife's Policy Duration is < Existing Policy Duration,----------then score = **-1**

4. **Inflation Option – Determine Inflation Protection Under Policy**

   Score: Compound Inflation provides more inflation protection then Simple, Optional or None

   Simple Inflation provides more inflation protection than Optional or No Inflation Protection

   Optional Inflation provides more inflation protection than No Inflation Protection

   - If MetLife's Policy Inflation Protection is > Existing Policy Inflation Protection,--------then score = **+1**
   - If MetLife's Policy Inflation Protection is = Existing Policy Inflation Protection,--------then score = **0**
   - If MetLife's Policy Inflation Protection is , Existing Policy Inflation Protection,----------then score = **-1**

Complete This Section:

ANNUAL PREMIUM:

Existing Policy $_____ Replacement Policy $_____ Difference $_____

SIGN & MAIL THIS FORM TO METLIFE

LONG-TERM CARE INSURANCE REPLACEMENT CHECKLIST

APPLICANT 2

COMPLETE FOR REPLACEMENTS INVOLVING METLIFE LONG-TERM CARE INSURANCE

To be completed by Producer & Submitted with Application

Features:	Existing Policy: Company:	Proposed Replacement MetLife Individual Business	Score
1. Nursing Facility or Comprehensive or Home Health Care			
2. Home Health Care Percent of Nursing Facility Daily Benefit Amount (DBA)			
3. Policy Duration			
4. Inflation Protection			
TOTAL SCORE			

CHECK ONE:

☐ **• IF VALUE OF SCORE IS A POSITIVE NUMBER (+), then the benefits of the MetLife Replacement Policy may be considered Better or Greater than the benefits of the Existing Policy**

☐ **• If Value of score is ZERO (0) or is a NEGATIVE NUMBER (-), then the benefits of the MetLife Replacement Policy may not be considered Better or Greater than the benefits of the Existing Policy.**

To be completed by Applicant:

I have reviewed this form with my producer.

_____
Signature of Applicant

_____
Name of Applicant (Please Print)

_____
Street Address

_____
City

_____
State Zip

To be completed by Licensed and Appointed Producer: I certify that each question was asked of the applicant and answered as recorded.

_____
Signature of Licensed and Appointed Producer

_____
Name of Licensed and Appointed Producer (Please Print)

_____
Phone Fax

_____
Street Address

_____
City

_____
State Zip

(over please)

MAIL THIS FORM TO METLIFE

APPLICANT 2

REPLACEMENT CHECKLIST

Instructions for Comparison & Scoring:

Complete All Questions – Respond on Page 48, Total Score, Complete Applicant & Producer Information, Return Form with Application.

1. **Indicate the Policy Coverages: Home Health Care OR Nursing Facility OR Comprehensive (Both Nursing Facility & Home Health Care)**

   Score: Comprehensive is GREATER than Nursing Home which is GREATER than Home Health Care

   - If MetLife's Coverage is > Existing Policy Coverage,----------then score = **+1**
   - If MetLife's Coverage is = Existing Policy Coverage,----------then score = **0**
   - If MetLife's Coverage is < Existing Policy Coverage,----------then score = **-1**

   If both policies provide comprehensive coverage, then complete #2, if not, skip to #3.

2. **Home Health Care Percentage (HHC%) – Indicate Amount of Home Health Care as a *percentage* of Nursing Facility Daily Benefit Amount (DBA)**

   Score: HIGHER percentage provides more coverage

   - If MetLife's Policy HHC% is > Existing Policy Coverage HHC%,----------then score = **+1**
   - If MetLife's Policy HHC% home care DBA is = Existing Policy Coverage HHC%,-----then score = **0**
   - If MetLife's Policy HHC% home care DBA is < Existing Policy Coverage HHC%,-----then score = **-1**

3. **Total Lifetime Duration – Indicate total policy duration: *Number of years (e.g., 2 years, 3 years, etc.)***

   Score: A LONGER duration provides more coverage

   - If MetLife's Policy Duration is > Existing Policy Duration,----------then score = **+1**
   - If MetLife's Policy Duration is = Existing Policy Duration,----------then score = **0**
   - If MetLife's Policy Duration is < Existing Policy Duration,----------then score = **-1**

4. **Inflation Option – Determine Inflation Protection Under Policy**

   Score: Compound Inflation provides more inflation protection then Simple, Optional or None
   Simple Inflation provides more inflation protection than Optional or No Inflation Protection
   Optional Inflation provides more inflation protection than No Inflation Protection

   - If MetLife's Policy Inflation Protection is > Existing Policy Inflation Protection,--------then score = **+1**
   - If MetLife's Policy Inflation Protection is = Existing Policy Inflation Protection,--------then score = **0**
   - If MetLife's Policy Inflation Protection is , Existing Policy Inflation Protection,----------then score = **-1**

Complete This Section:

ANNUAL PREMIUM:

Existing Policy $_____ Replacement Policy $_____ Difference $_____

SIGN & MAIL THIS FORM TO METLIFE

APPLICATION SUBMISSION CHECKLIST

AGENT

Please make sure the following are correct:

☐ Personal Worksheet is completed.
If the applicant chooses not to complete the Personal Worksheet, please complete the ***Authorization to Proceed Processing Application Form***.

☐ Only individual applicants complete this application.
Multi-Life program group applicants require different applications.

☐ Correct distribution channel is selected in Agent's Report.

☐ For Automatic Checking Account Deduction of premium, a voided check is included and Part E, Question 3 is completed and signed.

☐ All Health Information is complete.

☐ The ***Authorization to Release Information to MetLife*** Form is signed by the applicant(s).

☐ The California Authorization to Release Information is signed by the applicant(s), if the applicant(s) want us to provide medical information that is relevant to our underwriting decision, directly to them.

☐ All signatures boxes are complete.

☐ The Beneficiary Designation Form for the Return of Premium Rider should only be completed if the Applicant is selecting the Return of Premium Rider and chooses to designate a beneficiary other than their estate.

LTC01614(1017) 0505-7946

Metropolitan Life Insurance Company
New York, NY 10166
www.metlife.com