*Voluntary Term Life Insurance Program*
*for*

# RIO HONDO COMMUNITY COLLEGE

Certificate Number: 05372801

If you are eligible, Voluntary Term Life Insurance is available to you, your eligible spouse, and your eligible dependent children. This insurance option provides low cost, pure life insurance protection—it is an ideal way to help provide financial protection during your working years.

## ELIGIBILITY FOR THIS PROGRAM

**Employee:** (1) if your employer requires that you must be continuously employed by them for a minimum number of days, you must be continuously employed for at least that number of days; and (2) you must be actively performing the regular duties of your job for at least the required number of hours as defined in the Group Contract and work in the usual manner and at the usual place of employment or business (if you are not working due to illness or injury, you will *not* be eligible until you return to work); and (3) you must provide evidence of insurability satisfactory to MetLife, if we ask for it. If you are not working due to illness or injury, you will not be eligible until you return to work.

**Spouse:** Your spouse who is legally married (as determined by the laws of the state in which you live) to you is eligible to participate in this program. Spouse also means your registered domestic partner* as defined in the Group Contract. A spouse does not include anyone who is personally eligible as an employee. You must be covered in order for your spouse to be eligible for coverage.

*Your registered domestic partner means a person whose domestic partnership with you has been validly registered by the California Secretary of State; or a person with whom you have established a union other than marriage, recognized under California law as the equivalent of a registered domestic partner.

**Dependent Children:** Dependent children are your children from live birth to 26 years old. Your children include your legally adopted children, children placed with you for adoption prior to legal adoption, and each of your stepchildren, Registered Domestic Partner's children, and foster children. A child placed with you for adoption prior to legal adoption is considered your qualified dependent from the date of placement for adoption, and is treated as though the child were a newborn child born to you.

A dependent child does not include anyone who is personally eligible as an employee. If you and your spouse are both eligible as an employee, your children may be insured as dependent children of either you or your spouse, but not both of you. You must be covered in order for your dependent children to be eligible for coverage.

A qualified dependent may be confined for medical care or treatment, at home or elsewhere. If a qualified dependent is so confined on the day that your dependent's insurance under a coverage for that qualified dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

## BENEFITS

**Employee Coverage:**

| Classification | Maximum Benefit | Non-Medical Limit* |
|---|---|---|
| Superintendent, Management, Certificated, and Classified Employees. | $10,000 increments to a maximum of $500,000 not to exceed five (5) times annual earnings (rounded to the next highest $10,000). | Two (2) times annual earnings, rounded to the next highest $10,000 not to exceed $100,000. |
| All Members of the Board of Education | $10,000 increments to a maximum of $500,000. | $100,000. |
| Evidence of Insurability will be required on all employee amounts over the non-medical limit amount.<br>*To be eligible for non-medical limit, you must be an active employee and apply within 31 days of first becoming eligible for this coverage.<br>Annual earnings are defined as the gross amount of money paid to you by the employer in cash for performing the duties required of your job. Bonuses, overtime pay, earnings for more than 40 hours per week, and all other benefits are not included. | | |

**Dependent(s) Coverage*:**

**Spouse:** Your spouse's amount must be in **$10,000** increments, not to exceed **$500,000**. Non-Medical Limit of up to **$20,000** is available. The spouse can only select coverage if the employee enrolls.

**Dependent Children:** You may select from the following coverage amounts: **$2,500, $5,000, $10,000**.

Your spouse and dependent children can only participate if you have NOT been denied coverage.
***Dependents' coverage may not exceed 100% of your approved coverage amount.**

## HIGHLIGHTS

Premium will be waived for you, your spouse, and your children if **you**, the employee, are insured and become totally disabled for at least six consecutive months. Your total disability must occur while coverage is in force and prior to your attaining age 70. During the six-month waiting period, premiums for all coverage must be paid. Limitations and exclusions apply. Refer to the Group Contract for details.

**Accelerated Death Benefit**
The Accelerated Death Benefit for Terminal Illness allows individuals to "tap into" life insurance proceeds early. You can receive up to **80%** of the applicable Voluntary Term Life Insurance amount in the event of an insured's terminal illness. The maximum benefit payable under this option is **$500,000**. The balance of the coverage will be paid to the beneficiary at the death of the insured. Limitations and exclusions apply. Refer to the Group Contract for details.

Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered "terminally ill" You may wish to seek professional tax advice before exercising this option.

**Continuation of Coverage**
If your employment terminates for any reason or you become ineligible, you and your covered family may continue your Voluntary Group Term Life Insurance coverage on a direct payment basis at the same rate as long as the Group Contract remains in effect. YOU MUST CONTINUE your coverage in order to continue dependent coverage. If you elect this option, you will be billed on a semiannual or annual basis. A fee per billing will apply, and your premium cost is subject to change. You must sign an application for continuation within 31 days following the termination of your employment or eligibility. An insured on continued coverage may apply for conversion to permanent coverage at any time, but in no event more than 31 days after the termination of the Group Contract.

## EXCLUSIONS

**Suicide Exclusion**
If you or your covered dependent's death results from or is caused by suicide, while sane or insane: (1) A death benefit is not payable if you or your covered dependent dies within two years of the date you or your covered dependent became a covered person. But, MetLife will refund any premiums paid for your Voluntary Term Life Insurance or Voluntary Dependent Term Life Insurance under this coverage. (2) The amount of any increase in your or your dependent's death benefit is not payable if you or your covered dependent dies within two years of the date of the increase. But, Prudential will refund any premiums paid for that increase.

**Beneficiary**
You designate your own beneficiary. You, as the employee, will be the beneficiary of your spouse's and/or children's insurance.

**How to Apply**

Select the amount of coverage that best meets your needs and those of your family. Calculate your premium, then complete and sign the enclosed application and its payroll deduction authorization. Be sure to complete all questions accurately. Your spouse must sign if he/she is requesting insurance coverage. All applications are subject to the underwriting review and approval by MetLife. If you do not want coverage, simply sign and date the appropriate line at the top of the application. Whether you apply for coverage or choose not to participate, all applications and waivers must be returned to your employer.

**PREMIUM COST**

| Premium per $1,000 of Coverage for Employees and Spouses | | |
|---|---|---|
| **AGE** | **TENTHLY** | **MONTHLY** |
| Under 30 | .05 | .04 |
| 30-34 | .05 | .04 |
| 35-39 | .07 | .06 |
| 40-44 | .11 | .09 |
| 45-49 | .19 | .16 |
| 50-54 | .29 | .24 |
| 55-59 | .47 | .39 |
| 60-64 | .78 | .65 |
| 65-69 | 1.31 | 1.09 |
| 70+ | 2.22 | 1.85 |

| Children Coverage Options | TENTHLY COST | MONTHLY |
|---|---|---|
| $2,500 | .60 | .50 |
| $5,000 | 1.20 | 1.00 |
| $10,000 | 2.40 | 2.00 |

Employee/Spouse rates are based on the age of the covered individual. Your rates will automatically increase on the Contract Anniversary following the date you advance into the next higher age-bracket listed above. During the employee's or spouse's lifetime, a premium adjustment will be made immediately if any discrepancy is found in either the employee's or spouse's age or cost.

**Effective Date**

Your coverage will be effective on the first day of the month following the date that MetLife or its administrator approves your application. As an eligible employee if you qualify for the non-medical limit, the first two times annual earnings, rounded to the next highest $10,000 not to exceed **$100,000** will be effective on the first day of the month following the date you enroll. As an eligible Board Member if you qualify for the non-medical limit, the first **$100,000** will be effective on the first day of the month following the date you enroll. Your spouse's coverage will be effective on the first day of the month following the date he/she is approved for coverage. If your spouse qualifies for a non-medical limit, up to the first **$20,000** will be effective on the first day of the month following the date you enroll your spouse. Children coverage is effective when your coverage becomes effective. Spouse and dependent children coverage will not become effective unless you apply for and are approved for coverage.

**Delay of Effective Date**

Your Employee Insurance under a Coverage will be delayed if you do not meet the Active Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the first day you meet the Active Work Requirement and the other requirements for the insurance. The same delay rule will apply to any change in your insurance that is subject to this section. For Dependents Term Life coverage, if a Qualified Dependent is so confined on the day that your Dependents Insurance under a Coverage for that Qualified Dependent, or any change in that insurance that is subject to this section, would take effect, it will not then take effect. The insurance or change will take effect upon the Qualified Dependent's final medical release from all such confinement. The other requirements for the insurance or change must also be met.

**LIMITATIONS AND EXCLUSIONS**

This booklet highlights the features of your Voluntary Group Term Life Insurance coverage. Only the provisions, definitions, limitations, and exclusions of the Group Contract, Certificate, Riders, Endorsements, Applications and/or Enrollment Form, which together constitute the formal legal contract, will apply. A copy of the Group Contract is held by your employer and can be viewed upon request during your employer's normal business hours.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

## INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

**INSTRUCTIONS TO THE RECORDKEEPER** (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

**INSTRUCTIONS TO THE EMPLOYEE**

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

**INSTRUCTIONS TO THE PROPOSED INSURED** (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse/Domestic Partner or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

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

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email:
eoi@metlifeservice.com

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

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

MetLife

**Metropolitan Life Insurance Company, New York, NY 10166**

## STATEMENT OF HEALTH FORM

### GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

| Name of Group Customer/Employer/Association | Group Customer # | Reporting Location # |
|---|---|---|
| **RIO HONDO COMMUNITY COLLEGE** | **05372801** | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| 3600 WORKMAN MILL ROAD | WHITTIER | CA | 90601 |

### INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year

**Term Life Insurance**

- ☐ Basic Life: Indicate amount subject to medical underwriting $_____
- ☐ Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse/Domestic Partner Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____

### EMPLOYEE INFORMATION (To be Completed by the Employee)

| Name of Employee (First, Middle, Last) | Social Security # of Employee |
|---|---|
| | |

### YOUR INFORMATION (To be Completed by the Proposed Insured)

| Name (First, Middle, Last) | Relationship to Employee ☐ Self ☐ Spouse/Domestic Partner ☐ Child | ☐ Male ☐ Female |
|---|---|---|
| | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Date of Birth (MM/DD/YYYY) | Daytime Phone # | Home Phone # | Email Address |
|---|---|---|---|
| | | | |

**GEF02-1**
**ADM**
*(The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and
**GEF02-1**
**ADM** *applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

## HEALTH INFORMATION

### SECTION 1

**Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 12t, for "yes" answers, please provide full details in Section 2.**

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

| | | Yes | No |
|---|---|---|---|
| 1. | Your height ___ feet ___ inches Your weight ____ pounds | | |
| 2. | Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____ | ☐ | ☐ |
| 3. | Are you now pregnant? If "yes," what is your due date (month/day/year)? _____ | ☐ | ☐ |
| | If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____ | | |
| 4. | Are you now, or have you in the past 2 years, used tobacco in any form? | ☐ | ☐ |
| 5. | In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? | ☐ | ☐ |
| 6. | In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____ | ☐ | ☐ |
| 7. | Have you had any application for life, accidental death and dismemberment or disability insurance ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified or ☐ issued other than as applied for? Indicate reason _____ | ☐ | ☐ |
| 8. | Are you now receiving or applying for any disability benefits, including workers' compensation? | ☐ | ☐ |
| 9. | Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis. | ☐ | ☐ |
| 10. | **For residents of all states except CT, please answer the following question**: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **For CT residents, please answer the following question: To the best of your knowledge and belief,** have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | ☐ | ☐ |
| 11. | In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure? | ☐ | ☐ |
| 12. | Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | | |
| | a. cardiac or cardiovascular disorder? Indicate type _____ | ☐ | ☐ |
| | b. stroke or circulatory disorder (such as peripheral artery disease)? Indicate type _____ | ☐ | ☐ |
| | c. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____ | ☐ | ☐ |
| | d. anemia, leukemia or other blood disorder? Indicate type _____ | ☐ | ☐ |
| | e. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated | ☐ | ☐ |
| | f. asthma, COPD, emphysema or other lung disease? Indicate type _____ | ☐ | ☐ |
| | g. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ | ☐ | ☐ |
| | h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ | ☐ | ☐ |
| | i. memory loss? Indicate type _____ | ☐ | ☐ |
| | j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____ | ☐ | ☐ |
| | k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____ | ☐ | ☐ |
| | l. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____ | ☐ | ☐ |
| | m. lupus, scleroderma, auto immune disease or connective tissue disorder? | ☐ | ☐ |
| | n. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____ | ☐ | ☐ |
| | o. back, neck, knee, spinal, joint or other musculoskeletal disorder (such as herniated disc; back pain; cervical spondylosis; meniscal, cartilage or ligament tears or injuries; hip fracture; or tendonitis)? Indicate type _____ | ☐ | ☐ |
| | p. carpal tunnel syndrome? | ☐ | ☐ |
| | q. kidney, urinary tract or prostate disorder? Indicate type _____ | ☐ | ☐ |
| | r. thyroid or other gland disorder? Indicate type _____ | ☐ | ☐ |
| | s. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____ | ☐ | ☐ |
| | t. sleep apnea? Indicate type _____ | ☐ | ☐ |

**After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 12t.**

**GEF09-1a**
*(The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and **GEF09-1**
**HEA** *applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

**Personal Physician Information**

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (____) ____–____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

**Prescription Information**

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

☐ Check here if you are attaching another sheet for any additional medications.

**SECTION 2**

**Please provide full details below for each "Yes" answer to questions 5 through 12t in Section 1.** If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

**GEF09-1a**
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**HEA** *applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (___) ___-_____

**GEF09-1a**
*(The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and **GEF09-1**
**HEA** *applies to residents of Connecticut, North Dakota and Utah)*

## FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Colorado**: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

**Kansas and Oregon**: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

**Kentucky**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**

**Maryland**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey**: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**New York** (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**Pennsylvania and all other states:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**GEF09-1a**
*(The form number above applies to residents of all states except as follows: Form number* **GEF09-1** *applies to residents of Montana*; and **GEF09-1**
**FW** *applies to residents of Connecticut, North Dakota and Utah)*

Please complete all sections of this form. Incomplete forms will be returned to you.

## DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Sign Here

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

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

Sign Here

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

Relationship of Personal Representative

# AUTHORIZATION

**This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes**:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

**Note to All Health Care Providers:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Expiration, Revocation and Refusal to Sign:** This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

**By signing below, each proposed insured acknowledges his or her understanding that:**

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

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

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

Sign Here

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