

Term Life Insurance Plan



Endorsed by
**MEMBER
BENEFITS**
mysut
Working to Benefit You

NYSUT MEMBER BENEFITS HAS PARTNERED WITH METLIFE TO OFFER YOU TERM LIFE INSURANCE FOR ALL STAGES OF LIFE

What does Term Life Insurance protect?

- Life insurance can cover your family's needs if you're not there, including food, bills and debt.
- It can help pay for your children's education.
- It can help ensure your family stays in their home.
- It can help take care of those who depend on you.
- In short, life insurance can help replace your paycheck if you aren't there to earn it.

Term Life Plan Features:

- Accelerated Benefits option where you can receive up to 80 percent of your life insurance benefit before death if you are diagnosed as terminally ill with less than 12 months to live.
- Will Preparation services for you and your spouse at no cost*.
- Convenient payment options with payroll/pension deductions or direct bill.

The NYSUT Member Benefits Trust-endorsed Term Life Insurance Plan can help at any stage of your life. The plan provides coverage through age 84, so there is no need to look for replacement coverage just when your health may be starting to fail. Keep a portion of your coverage until you turn age 85.

How many months would your family last on your current life insurance?

Life insurance is a smart financial move.

- Life insurance is a predictable financial option.
- Beneficiaries usually receive the proceeds of your policy income-tax free.

Up to \$1 Million Available . . .

You and/or your lawful spouse or certified domestic partner have the opportunity to **purchase up to \$1 million of life insurance coverage under this plan**, if under age 65. Up to \$25,000 is also available for each of your eligible children.

* Will Preparation is offered by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.

When life changes, so should your life insurance.

- New family members, a new job, a move or even a raise all mean that your life insurance needs have changed.
- It's a good idea to review your protection annually to make sure your current coverage still meets your needs.

Get an idea of how much life insurance might be right for you.

- A rule of thumb is 60% of your annual income multiplied by your number of years to retirement.
- Try our coverage estimator tool at <http://www.lifeonlinecalculator.com>.

The Plan Features:

Accelerated Benefits

With the Accelerated Benefits Provision, you can decide to receive up to 80% percent of your life insurance benefit (up to \$500,000) before death if you become terminally ill with less than 12 months to live. These Accelerated Benefits may prove to be essential to pay for final medical costs, or to maintain the financial security of your family during a terminal illness. Accelerated Benefits may be taxable. Consult your tax advisor.

The Convenience of Payroll/Pension Deduction

If your local association has made arrangements for payroll deduction of NYSUT Member Benefits-endorsed programs, you and your lawful spouse or certified domestic partner both qualify for this convenient way to pay for your premiums from your paycheck.

Likewise, if you are retired, maintain NYSUT membership and are collecting a monthly pension benefit from the NYSTRS, NYSERS, NYCTRS or NYCBERS, or if you are receiving income from a monthly lifetime annuity payment from TIAA, you and your lawful spouse or certified domestic partner qualify for the convenience of pension deduction from your pension check. Premiums will automatically be deducted from the NYSUT member's paychecks over 20 or 26 pay periods, or from 12 monthly pension benefits. No checks to write and no payments to remember. Everything is handled automatically for you.

When you retire, your coverage will be put on direct semi-annual bill. Once you start to receive regular monthly pension benefits, you can change your payment option to pension deduction. While you are on direct bill awaiting the start of pension deduction, the payroll deduction discounted premium rate will continue for two billing cycles. Pension deduction is always made in 12 equal payments.

NYSUT members who select the payroll or pension deduction option also enjoy a 15 percent discount on their premiums.

Details are outlined in this brochure. Please take a few minutes to read it thoroughly.

Important questions and answers about the NYSUT Member Benefits-endorsed Term Life Insurance Plan with Accelerated Benefits

How do Accelerated Benefits work?

Should you or your insured lawful spouse or certified domestic partner become diagnosed as terminally ill (with a life expectancy of 12 months or less), you are eligible to receive up to 80 percent of your life insurance benefit before death. This can be used to help pay medical costs or help maintain financial security during a difficult time.

The minimum benefit is the lesser of \$20,000 or 25 percent of your life insurance amount. The maximum benefit is the lesser of \$500,000 or 80 percent of your life insurance amount. The remainder of your benefit will be payable to your beneficiary after death (children's coverage not included in the Accelerated Benefits provision).

There is no added cost for this provision. Full details of this benefit are outlined in your Certificate of Insurance. Receipt of Accelerated Benefits may be taxable. Consult your personal tax consultant for details. To request this benefit, you must notify the Plan Administrator in writing and submit proof of the terminal illness.

Can my coverage be canceled by MetLife?

Your coverage cannot be cancelled as long as you are under age 85, maintain NYSUT membership or remain the lawful spouse or certified domestic partner of a NYSUT member, pay your premiums when due and the Member Benefits Group Policy remains in force.

Can I convert my coverage?

You have the option to convert to an individual policy of life insurance ("new policy") from MetLife if your Life Insurance ends for any of the reasons stated below:

- You cease to be in an eligible class for any reason; or
- The Group Policy ends; or
- Your Life Insurance is reduced:
 - On or after the date You attain age 65; or
 - Due to an amendment of the Group Policy.

You must apply during the application period in accordance with the conditions and requirements in the certificate. Your new policy may be for a like or lesser amount of coverage in force on the date of conversion. If you opt not to convert during the application period, you will not have the option to convert that amount at a later date.

What about coverage for my lawful spouse or certified domestic partner and children?

Your lawful spouse or certified domestic partner under age 85 may apply for insurance. Applicants under age 65 may apply for up to \$1 million in coverage. Each unmarried, dependent child age 15 days to age 23 is eligible for \$25,000 of coverage. Just one low premium covers all of your children! Child coverage may be included in either your certificate or your lawful spouse's or certified domestic partner's, but not both.

Note: A person who is eligible to apply as a member is not eligible to apply as a lawful spouse or certified domestic partner (i.e., in situations where a NYSUT member's lawful spouse is also a NYSUT member, they may each apply for \$1 million in coverage, but one could not apply for \$1 million as a member and another \$1 million as a lawful spouse of a member).

Coverage for a spouse ends on the date of divorce. An ex-spouse may only continue to participate if he or she joins NYSUT as an associate member.

If I use Payroll or Pension Deduction, how much can I save on premium rates?

By choosing to pay premiums through payroll or pension deduction, you can take advantage of rates that are discounted by 15 percent.

If I use Payroll Deduction, what happens to my Payroll Deduction life insurance when I retire?

As long as you retain your NYSUT membership as a retiree or remain the lawful spouse or certified domestic partner of a NYSUT member, you can maintain your life insurance coverage. Your premium will be transferred from payroll deduction to individual billing on a semi-annual basis. Once you start to receive monthly pension benefits, you can change your payment option to pension deduction. While on individual billing awaiting the start of pension deduction, the payroll deduction discounted premium rate will continue for two billing cycles.

If I use Payroll Deduction, can I keep my life insurance coverage if I change employers and my new employer does not offer payroll deduction?

Yes! Your payment option will change to individual billing on a semi-annual basis. Remember, you must also retain your NYSUT membership or remain the lawful spouse or certified domestic partner of a NYSUT member to maintain your life insurance coverage.

Are there any exclusions?

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

May I return my Certificate if I'm not satisfied?

If you are not completely satisfied with the terms of your Certificate, you may contact Mercer Consumer toll-free at 888-386-9788, without claim within 30 days. Your coverage will be void from the start and you will receive a full refund — no questions asked!

Applying for the NYSUT Member Benefits Trust-endorsed Term Life Insurance Plan is easy!

Who May Apply?

NYSUT members, agency fee payers, and their lawful spouses or certified domestic partners under age 85 may apply for Member Benefits-endorsed Term Life Insurance. Each applicant must complete a separate application. If additional information is needed, you will be contacted by the underwriting company. Do not cancel any other life insurance until after you are accepted into this program. In-service members must be actively at work when insurance is to take effect. If not, insurance will take effect on the day the member returns to work.

Lawful spouses and retired members must be able to perform the normal activities (as defined by the policy) of a person of like age, sex or retired status on the date insurance is to take effect. If not, the insurance will take effect on the day one resumes such activities. **IMPORTANT:** A lawful spouse or certified domestic partner under age 85 may apply for coverage on himself or herself as an applicant owner, provided coverage has been applied for on a written form satisfactory to MetLife that has been signed by the applicant owner and the NYSUT member or associate member. The spouse will then be considered the owner of the coverage. The applicant owner is the sole owner of all rights, title and interest.

If you are also applying for dependent coverage and the dependent is hospitalized on the date his or her insurance is to take effect, it will take effect on the day after he or she is discharged.

How to Apply

1. **Complete**, date and sign the application.
2. Be sure to indicate the amount of life insurance you desire on the application.
3. If you choose payroll/pension deduction, simply complete the enclosed application and mail it along with the appropriate deduction authorization card to the Plan Administrator. Your lawful spouse (or certified domestic partner) also qualifies for payroll deduction through your paycheck or pension deduction through your monthly pension benefit.

If you choose individual billing, simply complete the enclosed application and mail it to the Plan Administrator. Either way, send no money now; you will be billed later.

4. Mail your application and appropriate deduction authorization card if applicable to:

Mercer Consumer, a service of Mercer Health
& Benefits Administration LLC
Plans Administrator
P.O. Box 9186
Des Moines, IA 50306-9186

Two Methods of Premium Payment — Payroll/Pension Deduction or Individual Billing

If payroll/pension deduction of NYSUT Member Benefits-endorsed programs is available to you and you choose this as your payment option, please follow the instructions and the rates in the payroll/pension deduction section below.

If Member Benefits payroll/pension deduction is not available to you, individual billing on a semi-annual basis is available. Please follow the instructions and rates in the individual billing section.

Payroll/Pension Deduction

SEND NO MONEY.

To determine what your approximate deduction amount will be: Multiply the deduction amount for your age bracket and deduction schedule by the number of units desired (e.g., for \$100,000 at age 39 with 20 deductions, multiply \$0.14 by 20 units = \$2.80). If you are applying for child coverage, just add \$1.70 (for 12 deductions), \$1.03 (for 20 deductions) or \$0.79 (for 26 deductions) to your payroll/pension deduction amount. (\$0.79, \$1.03 or \$1.70 covers all your dependent children, no matter how many.)

Your lawful spouse or certified domestic partner qualifies for payroll/pension deduction through your payroll/pension check. The Payroll or Pension Deduction Authorization Form must be completed by the NYSUT **member** and returned with the lawful spouse's or certified domestic partner's application.

Approximate Payroll/Pension Deduction Amount Rates effective 3/1/2018

Applicant's Age	Life Insurance Per Unit*	Rates Based on 26 Payroll Deductions (UUP, PSC/CUNY)	Rates Based on 20 Payroll Deductions (NYSUT, UFT)	Rates Based on 12 Pension Deductions
Under 30	\$5,000	\$0.08	\$0.10	\$0.17
30 – 34	\$5,000	\$0.09	\$0.12	\$0.20
35 – 39	\$5,000	\$0.11	\$0.14	\$0.23
40 – 44	\$5,000	\$0.16	\$0.20	\$0.34
45 – 49	\$5,000	\$0.25	\$0.32	\$0.53
50 – 54	\$5,000	\$0.36	\$0.46	\$0.76
55 – 59	\$5,000	\$0.56	\$0.72	\$1.20
60 – 64	\$5,000	\$0.97	\$1.26	\$2.10
65 – 69	\$3,000	\$0.95	\$1.23	\$2.05
70 – 74	\$2,500	NA	NA	\$3.40
75 – 79	\$2,500	NA	NA	\$5.69
80 – 84	\$2,500	NA	NA	\$9.80
Children	NA†	\$0.79	\$1.03	\$1.70

Please note: Payroll and pension deduction amounts are approximate, due to rounding.

Please note: Under age 65, the value of each life insurance unit is \$5,000. For ages 65–69, the value of each life insurance unit reduces to \$3,000; and for ages 70–84, each life insurance unit reduces to \$2,500. Coverage reduces by 40 percent on the billing anniversary date that coincides with or next follows the date the insured attains age 65. Coverage reductions at age 70 depend upon the coverage amount in force at age 69. Benefit amounts of \$20,000 or more will reduce to \$20,000 at age 70, \$10,000 at age 75 and \$5,000 at age 80. For those with lesser amounts of existing term life insurance benefits: Benefit amounts of \$10,000 to \$19,999 will reduce to \$10,000 at age 70, \$5,000 at age 75 and \$2,500 at age 80. Coverage terminates at age 85.

†Child premium rate is for a total benefit of \$25,000 per covered child, subject to state variations.

Individual Billing

SEND NO MONEY NOW. YOU WILL BE BILLED LATER.

To determine what your semi-annual premium will be: Multiply the semi-annual premium for your age bracket by the number of units desired (e.g., for \$100,000 at age 39, multiply \$1.62 by 20 units = \$32.40). If you are applying for child coverage, just add \$12.05 to your semi-annual premium. (\$12.05 covers all your dependent children, no matter how many.)

Semi-Annual Premium Rates Rates effective 3/1/2018

Applicant's Age	Life Insurance Per Unit*	Semi-Annual Direct Bill
Under 30	\$5,000	\$1.15
30 – 34	\$5,000	\$1.39
35 – 39	\$5,000	\$1.62
40 – 44	\$5,000	\$2.36
45 – 49	\$5,000	\$3.72
50 – 54	\$5,000	\$5.37
55 – 59	\$5,000	\$8.43
60 – 64	\$5,000	\$14.80
65 – 69	\$3,000	\$14.43
70 – 74	\$2,500	\$24.00
75 – 79	\$2,500	\$40.00
80 – 84	\$2,500	\$69.00
Children†	NA†	\$12.05

* Your age determines the maximum amount of coverage you may apply for under the Term Life Plan. Only those under age 85 may apply. Applicants under age 65 may apply for up to \$1 million (200 units) of insurance [a minimum of \$25,000 (5 units) must be purchased]. Applicants ages 65–69 may apply for \$30,000 (10 units); ages 70–74 may apply for \$20,000 (8 units); ages 75–79 may apply for \$10,000 (4 units); and ages 80–84 may apply for \$5,000 (2 units).

Rates are based on age at date of issue and on anniversary date. Premiums increase every time the participant enters a five year age category.

You may also calculate your premium using our Personalized Rate Quote tool, which can be located on the Mercer Life Insurance page at www.nysutmbteinsurance.com.

Underwritten by:

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

Administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 9186
Des Moines, IA 50306-8838
In CA d/b/a Mercer Health & Benefits Insurance Services LLC
AR Insurance License #100102691 • CA Insurance License #0G39709 • MN
Insurance License #40291395
OK Insurance License #100100336 • TX Insurance License #1850385

About Our Role and Compensation

In this transaction, Mercer Consumer, a service of Mercer Health & Benefits Administration LLC, is acting as the exclusive insurance agent and program manager for The Metropolitan Life Insurance Company (Insurer) for this type of coverage, and not as your insurance broker. As the agent for Insurer, Mercer Consumer may provide these services: enrollments, ongoing servicing, billing, marketing, customer administrative, underwriting, claim servicing, and communications. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and non-monetary compensation from insurers or from other insurance intermediaries, which may be contingent upon such factors as volume, growth or retention of business. This compensation may include payment from insurers for marketing-related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation upon your request. You may obtain this information by calling us toll-free at 1-888-206-5088 for specific details.

The MetLife Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

QUESTIONS? CALL US!

A licensed representative will be happy to assist you with any questions you may have. Call Mercer Consumer toll-free at 888-386-9788, weekdays from 9 a.m. to 9 p.m. or Saturdays from 9 a.m. to 2 p.m. (EST).

You may also visit
www.nysutmbteinsurance.com.

Email: customerservice.service@mercercor.com

***Remember – if you are
applying through payroll
or pension deduction,
complete the appropriate
Authorization Card.***



metlife.com

The Plan Brochure provides only a brief overview of the Life plan. A more complete description of the benefits provisions, conditions, limitations and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern. Like most group life insurance policies, MetLife group policies contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force. Contact the plan administrator Mercer Consumer for complete costs and details.

Not approved in all states.

Metropolitan Life Insurance Company | 200 Park Avenue, | New York, NY 10166
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ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION	
Name of Policyholder: NYSUT Member Benefits Trust	Group Customer # 35370
Source Code (Office Use Only)	
NYSUT DB 53162/53163/1014/53288-S	UFT PRD 53148/53149/1007/53289
NYSUT PRD 53160/53161/1015/53288	NYSUT DB RET 53156/53157/1016/53288-S
UFT DB 53150/53151/1006/53289-S	NYSUT PEN RET 53154/53155/1017/53288

YOUR ENROLLMENT INFORMATION			
I am the: <input type="checkbox"/> NYSUT Member <input type="checkbox"/> Spouse/Domestic Partner ¹			
Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Member Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)	Phone #	Email Address	
NYSUT Member Name (First, Middle, Last)	NYSUT ID #	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Policyholder's Group Insurance Program.

Term Life Insurance
<input type="checkbox"/> Term Life ^{1,2,3} Enter a multiple of \$5,000 \$ _____ up to \$1,000,000 (under age 65) Enter a multiple of \$3,000 \$ _____ up to \$30,000 (age 65-69) Enter a multiple of \$2,500 \$ _____ up to \$5,000 (age 80-84), up to \$10,000 (age 75-79), up to \$20,000 (age 70-74).
<input type="checkbox"/> Dependent Child Life ³ \$25,000

Dependent Information			
If you are applying for coverage for your Child(ren), please provide the information requested below:			
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female	
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.			

OWNER INFORMATION (To be Completed by the Spouse/Domestic Partner, if enrolling for Spouse/Domestic Partner coverage)		
NOTE: The Spouse/Domestic Partner of the NYSUT member is considered the owner of Spouse/Domestic Partner coverage. NYSUT Members do not need to complete this section.		
Name of Owner (First, Middle, Last) if the owner is a person other than the member:	Date of Birth (MM/DD/YYYY)	Social Security # of Owner - -
Address (Street, City, State, Zip Code)	Phone #	

¹ Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest. ² Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor. ³Amounts will be subject to state limits, if applicable.

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)

SUBMISSION INSTRUCTIONS - A separate form must be completed by each proposed insured.
After completion, sign and date the form on the last page where indicated. Make a copy for your records and return to:
Mercer Consumer, P.O. Box 9186, Des Moines, IA, 50306-9186.
Please note that coverage may not be available in all states. See your plan administrator for additional information.

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your Name _____

Your height _____ feet _____ inches Your weight _____ pounds

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now receiving or applying for any disability benefits, including workers' compensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | | |
| a. cardiac or cardiovascular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. stroke or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cancer, Hodgkin's disease, lymphoma or tumors? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. asthma, COPD, emphysema or other lung disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. ulcers, stomach, hepatitis or other liver disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. colitis, Crohn's, diverticulitis or other intestinal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. epilepsy, paralysis, seizures, dizziness or other neurological disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. multiple sclerosis, ALS or muscular dystrophy? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. back, neck, knee, spinal, joint or other musculoskeletal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. mental, anxiety, depression, attempted suicide or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you currently taking any other prescribed medications? | <input type="checkbox"/> | <input type="checkbox"/> |

GEF09-1

HEA

(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)

- | | | |
|--|--------------------------|--------------------------|
| 7. In the past 3 years, have you been Hospitalized as defined below (not including well-baby delivery)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | | |
| 8. In the past 2 years, have you used tobacco or nicotine in any form? | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered "Yes" to any of the above questions, you must also complete a Statement of Health form. Mercer Consumer will mail you the Statement of Health form upon receipt and review of this enrollment form.

GEF09-1

HEA-SUPP

(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-SUPP applies to residents of Connecticut, North Dakota and Utah)

FRAUD WARNINGS

Before signing this enrollment 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.

GEF09-1

FW

*(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)

BENEFICIARY DESIGNATION

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical 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. For Members and Associate Members, I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work. For Members, Associate Members or Retired Members, if I am not actively at work, I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
3. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

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.



_____	_____	_____
Signature of Member	Print Name	Date Signed (MM/DD/YYYY)



_____	_____	_____
Signature of Owner/Spouse/ Domestic Partner (if applicable)	Print Name	Date Signed (MM/DD/YYYY)

**GEF09-1
DEC**

*(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

DEC applies to residents of Connecticut, North Dakota and Utah)

Premium Mode / Payment Option Section:
Select one mode of payment:
<input type="checkbox"/> Payroll Deduction (Please complete the Payroll Deduction Authorization)
<input type="checkbox"/> Pension Deduction (Please complete the Pension Deduction Authorization)
<input type="checkbox"/> Direct Bill Semi-Annually

The MetLife Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

▼ Return with application ▼

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION			
NYSUT Member Benefits Trust	NYSUT Member Benefits Corporation	NYSUT Member Benefits CMM Insurance Trust	
(Please Print):			<p>Please check your union membership affiliation:</p> <p><input type="checkbox"/> UFT <input type="checkbox"/> UUP <input type="checkbox"/> PSC/CUNY*</p> <p><input type="checkbox"/> All other NYSUT Locals</p> <p>The amount of deductions will be determined by NYSUT Member Benefits based on the programs chosen, and may be adjusted to ensure that premiums are paid in full.</p> <p><i>*This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.</i></p>
Last Name _____ First _____ Middle Initial _____			
Address _____ NYSUT ID # _____			
Home Phone # _____ Member's SS # _____			
<p>I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.</p>			
Signature of Employee _____		Date _____	
<p>Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.</p>			

NYSUT MEMBER BENEFITS PENSION DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust

NYSUT Member Benefits Corporation

NYSUT Member Benefits CMM Insurance Trust



(Please Print):

Last Name _____ First _____ Middle Initial _____

Address _____

Home Telephone No. () _____ NYSUT ID # _____

Soc. Sec. # _____ Authorization is for _____
(name of plan)

Please Note: You must be retired for a minimum of six months to be eligible for pension deduction.

Read statements on the reverse side. Signature and date are required.

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

1.5K, 5/16, I-106

CHECK ONE BOX ONLY - SIGN AND DATE BELOW

- | | | |
|---|---|--|
| <p><input type="checkbox"/> I belong to the Teachers' Retirement System of the CITY of New York (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994. The TRS is authorized to continue taking such deductions until NYSUT Member Benefits receives written notice from me to the contrary.</p> <p><input type="checkbox"/> I belong to the New York City Board of Education Retirement System (BERS).</p> <p><input type="checkbox"/> I belong to the NYSUT Staff Pension Program.</p> | <p><input type="checkbox"/> I belong to the New York STATE Teachers' Retirement System (NYSTRS), or</p> <p><input type="checkbox"/> I belong to the New York STATE Employees' Retirement System (NYSERS) and I hereby request monthly withholding of union deductions from my monthly benefit as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law. The NYSTRS or NYSERS is authorized to continue taking such deductions until NYSUT Member Benefits receives written notice from me to the contrary.</p> <p>NYSERS #: _____</p> | <p><input type="checkbox"/> I am a TIAA-CREF participant and hereby request a monthly withholding of deductions from my TIAA-CREF monthly lifetime annuity income for the purchase of coverages provided through NYSUT Member Benefits' Pension Advantage program. TIAA-CREF is authorized to continue taking such deductions until Member Benefits receives written notice to the contrary. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA-CREF, all deductions I have authorized TIAA-CREF to take on my behalf will terminate immediately.</p> |
|---|---|--|

I expressly acknowledge and understand that NYSUT Member Benefits will determine the exact deductions to be withheld monthly and that any questions regarding the amount will be directed by me to Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity as referenced on the reverse side. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee. I hereby certify to the NYCTRS, NYSTRS, NYSERS, or TIAA-CREF that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as provided by law.

Signature _____

Date _____

AUTHORIZATION

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

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

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

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

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

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, your employer for a plan administration purpose 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.



_____ Signature of Applicant		_____ Date Signed (MM/DD/YYYY)
_____ Print Name	_____ State of Birth	_____ Country of Birth



Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, 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

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company

MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.