Group Disability Income Plan

FOR MEMBERS OF THE MSBA

Disability Income Insurance Protection helps replace income lost while you are disabled. It is a very important element of anyone's insurance portfolio since it is specifically designed to help provide income so you can continue to support your family and pay your bills if you're unable to work because of sickness or injury.

Who is eligible to apply?

All members of the Minnesota State Bar Association, who are under the age of 60, reside in the United States, and actively at work in their profession (at least 30 hours/week) may apply for coverage.

Acceptance into this Plan is subject to evidence of insurability. If you apply for Disability Income Insurance, you must provide MetLife evidence of your insurability. If you apply for an increase in Disability Income Insurance, you must provide MetLife evidence of your insurability. The evidence of insurability is to be given at your expense.

How much insurance is available?

Members may elect a monthly benefit amount up to $10,000, provided that when combined with other disability insurance you may have in force the total does not exceed 60% of your average monthly earnings for the 12 month period immediately preceding your application. Income does not include commissions, bonuses, overtime pay and other extra compensation. Business owners and self-employed members should consult with your plan administrator to calculate your monthly benefit amount.

Choice of Elimination Periods

Your elimination period is the period of your disability your plan does not pay benefits. With this application, you can choose elimination periods of 30, 60, 90 or 180 days.

Choice of Benefit Periods

Eligible MSBA members have a choice of two benefit plans.

• **Basic Plan/5 Year Plan:** benefits are payable for up to five years (60 months).

QUESTIONS?

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• **Career /Reducing Benefit Duration Plan:** This Plan pays benefits up to age 65 for disabilities that start prior to age 60. For disabilities starting on or after age 60, benefits will be paid as follows.

60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Both plans provide coverage when you are disabled due to sickness or as a direct result of an accidental injury.

Disabled or **Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are unable to earn more than 80% of your Pre-Disability Earnings at Your Own Occupation from any employer in the National Economy; and
- Unable to perform each of the material duties of Your Own Occupation for any employer in the National Economy.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If you are disabled and have received a Monthly Benefit for 12 months MetLife will adjust your Pre-Disability Earnings only for the purposes of determining whether you continue to be disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

- MetLife will add to your Pre-Disability Earnings an amount equal to the product of your Pre-Disability Earnings times the lesser of 7%; or
- The annual rate of increase in the Consumer Price Index for the prior calendar year.

In addition, both plans provide the following Rehabilitation Incentives.

Rehabilitation Program Incentive

If you participate in a Rehabilitation Program, MetLife will increase your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before we reduce your Monthly Benefit by any other income.

Work Incentive

While you are disabled, we encourage you to work. If you work while you are disabled and receiving Monthly Benefits, your Monthly Benefit will be increased by your Rehabilitation Program Incentive. Your Monthly Benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted Monthly Benefit plus the amount you earn from working and the income you receive from Other Income exceeds 100% of your Pre-Disability Earnings as calculated in the definition of Disability. In addition, the Minimum Monthly Benefit will not apply.

Limit on Work Incentive

After the first 12 months following your return to work, MetLife will reduce your Monthly Benefit by 50% of the amount you earn from working while disabled.

ADDITIONAL LONG TERM BENEFIT:
SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH

If you die while you are Disabled and were entitled to receive Monthly Benefits under this certificate, Proof of your death must be sent to MetLife. When we receive such Proof, MetLife will pay the benefit described in this section.

Benefit Amount

The benefit amount will be equal to 3 times the lesser of: the Monthly Benefit You receive for the calendar month immediately preceding your death; the Monthly Benefit you were entitled to receive for the month you die, if you die during the first month that Disability benefits are payable. The MetLife will reduce the benefit amount by any overpayment we are entitled to recover.

Waiver of Premium

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost of any disability income insurance.

Premium Information

Your insurance cost is based on your attained age when your coverage becomes effective and increases on the first premium due date after you reach a higher age bracket.

Semi-Annual Per $100 of Covered Benefit	30- Day Elimination Period		60- Day Elimination Period		90- Day Elimination Period		180- Day Elimination Period	
Age	**Career Plan**	**Basic Plan**	**Career Plan**	**Basic Plan**	**Career Plan**	**Basic Plan**	**Career Plan**	**Basic Plan**
Under 30	$7.38	$3.25	$6.20	$2.73	$5.00	$2.20	$4.50	$1.80
30-39	$10.33	$4.28	$8.68	$3.60	$7.00	$2.90	$6.40	$2.40
40-49	$17.26	$7.53	$14.51	$6.32	$11.70	$5.10	$10.60	$4.20
50-59	$27.89	$13.43	$23.44	$11.28	$18.90	$9.10	$17.10	$7.50
60-64	$27.59	$20.07	$23.19	$16.86	$18.70	$13.60	$15.40	$11.20
65-69*	$24.49	$24.49	$20.58	$20.58	$16.60	$16.60	$13.70	$13.70

HOW TO CALCULATE YOUR PREMIUM

1. Determine the monthly benefit you want. (Must be in multiples of $500.) Divide by 100.
2. Select the PLAN and the WAITING PERIOD you want. Look up the cost for your age bracket.
3. Multiply the cost by the number you derived in Step 1.

For Example: A 45-year-old member is applying for a $3,000 per month benefit and a 90-day waiting period under the Career Plan.
$3000 ÷ 100 = 30 x $11.70 = $351.00 semi-annual premium
(Annual and quarterly payment modes are also available.)

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

QUESTIONS?

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Effective Date of Coverage

Coverage will become effective the 1st day of the month on or next following the month the application is approved. You must meet all eligibility requirements on the effective date including being actively at work as defined under this coverage.

What Is Not Covered

We will not pay for any Disability caused or contributed to by: 1. war, whether declared or undeclared, or act of war, insurrection or rebellion; 2. your active participation in a riot; 3. intentionally self-inflicted injury; 4. attempted suicide; or 5. commission of or attempt to commit or taking part in a felony.

Termination

Your insurance under the Policy will cease on the first to occur of: 1. the date the Group Policy ends; 2. the the date insurance ends for Your class; 3. The end of the period for which the last premium has been paid for You; 4. The date You cease to be in an eligible class, if You are not Disabled on that date; 5. the last day of the calendar month in which You ceased Active Work, if You are not Disabled; 6. the last day of the calendar month you retire; 7. the date you attain age 70; or 8. the date You cease to be a Member of the Participating Association.

HOW TO APPLY

In three easy steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application form.
2. Do not send any money until MetLife Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.
3. Mail the completed Application to:
   MSBA Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

PLEASE NOTE

The information you supply when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals. Complete medical information should include the name of the physician(s) or hospital(s), street address (and suite or room number), city, state and zip code. Also, a brief description of the nature of illness or injury, symptoms, treatment and results. The insuring company relies on your answers and statements. Misstatements or failures to report information on your Application may be used as the basis for denying or reducing claim benefits, or even invalidating your insurance.

30-DAY FREE LOOK

When you receive your Policy, read it carefully. If you're not completely satisfied with the terms of your new insurance plan, simply return your Policy, without claim, within 30 days and your premium will be promptly refunded. No questions asked!

HOW TO FILE A CLAIM

To file a claim, write the Administrator for the proper forms.

QUESTIONS?



1-800-501-5776 **customerservice.service@mercer.com** **www.msbainsure.com**

MSBA

Underwritten by:

MetLife

Metropolitan Life Insurance
Company New York, NY 10166

This brochure contains a partial description of coverages. For a complete description of coverage, refer to Master Policy 215425-1-G issued to Minnesota State Bar Association and/or your certificate. This plan may not be available in all states. Contact your plan administrator for details.

Administered by:

Mercer

Mercer Consumer, a service of Mercer Health &
Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Consider Your Eligibility

Before you request coverage, you must be a member in good standing of MSBA. You must be a member for 30 days before initiating your insurance requests. If you have any questions about membership, see the MSBA home page at www.mnbar.org.

QUESTIONS?

1-800-501-5776 **customerservice.service@mercer.com** **www.msbainsure.com**

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:
U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust

Sponsoring/Participating Association (if different from Policyholder)	Group Customer #
Minnesota State Bar Association	**215425**

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Phone #	Date of Birth (MM/DD/YYYY)	
Email Address	☐ New Enrollment ☐ Change in Enrollment	Date of Membership (MM/DD/YYYY)	

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you? ☐ Yes ☐ No

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.

Disability Income Insurance

Select your monthly benefit:

☐ Enter a multiple of $500 up to a maximum of $10,000 not to exceed 60% of your predisability earnings. $ _____

Indicate your waiting period:

☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Select Benefit Period:

☐ To Age 65/Reducing Benefit Duration ☐ 5 years

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*;
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

After completion, **sign and date the form on the last page where indicated**. Make a copy for your records and return to
Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. BOX 10374, Des Moines, IA 50306-8812
Questions? Call 1-800-501-5776

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

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 12k, for "yes" answers, please provide full details in Section 2.

Note: You do not have to disclose an HBV (Hepatitis B Virus), HCV (Hepatitis C Virus) or HIV (AIDS Virus) test or any other test to determine the presence of a Bloodborne Pathogen which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of an Emergency Medical Services Person at a hospital or medical care facility; (3) to an Emergency Medical Services Person who was tested as a result of performing an emergency medical service.

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. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐	☐
11. 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? Indicate type _____	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. epilepsy, paralysis, seizures or other neurological disorder?	☐	☐
Specify date of last seizure (month/year) _____ Indicate type _____		
i. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	☐	☐
j. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
k. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
12. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
b. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐

c. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ ☐ ☐
d. memory loss? Indicate type _____ ☐ ☐
e. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____ ☐ ☐
f. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type _____ ☐ ☐
g. carpal tunnel syndrome? ☐ ☐
h. kidney, urinary tract or prostate disorder? Indicate type _____ ☐ ☐
i. thyroid or other gland disorder? Indicate type _____ ☐ ☐
j. dizziness? ☐ ☐
k. 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 12k.

The term "**Emergency Medical Services Person**" means: (1) an individual employed or receiving compensation to provide out-of-hospital emergency medical services such as a firefighter, paramedic, emergency medical technician, licensed nurse, rescue squad person, or other individual who serves as an employee or volunteer of an ambulance service as defined under chapter 144E or a member of an organized first responder squad that is formally recognized as a political subdivision in the state, who provides out-of-hospital emergency medical services during the performance of the individual's duties; (2) an individual employed as a licensed peace officer under section 626.84, subdivision 1; (3) an individual employed as a crime laboratory worker while working outside the laboratory and involved in a criminal investigation; (4) any individual who renders emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care who is acting as a good samaritan under section 604A.01; and (5) any individual who, in the process of executing a citizen's arrest under section 629.30, may have experienced a significant exposure to a Source Individual.

The term "**Source Individual**" means an individual, living or dead, whose blood, tissue, or potentially infectious body fluids may be a source of Bloodborne Pathogen exposure to an emergency medical services person. Examples include, but are not limited to, a victim of an accident, injury, or illness or a deceased person.

The term "**Significant Exposure**" means contact likely to transmit a Bloodborne Pathogen, in a manner supported by the most current guidelines and recommendations of the United States Public Health Service at the time an evaluation takes place, that includes: (1) percutaneous injury, contact of mucous membrane or nonintact skin, or prolonged contact of intact skin; and (2) contact, in a manner that may transmit a Bloodborne Pathogen, with blood, tissue, or potentially infectious body fluids.

The term "**Bloodborne Pathogens**" means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immune Deficiency Virus (HIV).

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 12k 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: (____) ____-____

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 to the extent required by applicable law.

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 Insurance): 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.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete, including health information, to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am actively at work on the date I am enrolling and that I was actively at work. 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.
3. 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. 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 applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	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*;
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

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.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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

MetLife
Metropolitan Life Insurance Company, New York, NY

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.

MetLife

Delaware American Life Insurance Company
Hyatt Legal Plans, Inc.
Hyatt Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

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.

SECTION 1: 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.

SECTION 2: 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.

SECTION 3: 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.

SECTION 4: 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, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a 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. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: 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

SECTION 6: 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

SECTION 7: 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.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. 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.

SECTION 9: 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. A detailed notice shall be furnished to you upon request. 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 the MetLife companies listed at the top of the first page.