MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:				Sponsoring Association:	
U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust				**American Professional Practice Association (APPA)**	
Group Customer # **158966**	Report # **158966**	Sub Code	Branch	Date of Membership (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

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

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 no contributions are required for Basic AD&D. I understand that contributions are required for the benefits I select below.

► You must complete the Health Information section of this form and the enclosed Authorization for all amounts of Supplemental Life and Dependent Spouse/Domestic Partner Life Insurance.

Term Life Insurance

☐ Supplemental Life [1]

Enter a multiple of $25,000 $_____ up to $1,000,000.

☐ Dependent Spouse/Domestic Partner [2] Life [1,3]

Enter a multiple of $25,000 $_____ up to $1,000,000.

☐ Dependent Child Life [3] $10,000

Accidental Death & Dismemberment (AD&D) Insurance

☐ Supplemental/Optional AD&D

Enter a multiple of $25,000 up to a maximum of $500,000. $_____

☒ Basic AD&D (Benefit amount is $10,000. You must be enrolled in Supplemental/Optional AD&D.)

☐ Dependent Spouse/Domestic Partner [2] AD&D

Enter a multiple of $25,000 up to a maximum of $500,000. $_____

☐ Dependent Child AD&D $10,000

☐ Voluntary AD&D

First select your option

☐ Member Only ☐ Member + Spouse/Domestic Partner [2]

☐ Member + Child(ren) ☐ Member + Spouse/Domestic Partner [2] + Child(ren)

Then select your level of coverage

Enter a multiple of $25,000 up to a maximum of $500,000. $_____

[1] 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.

[2] 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.

[3] Amounts 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*;
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated**. Make a copy for your records and return to APPA 12444 Powerscourt Dr, Suite 500A, St Louis, MO 63131

APPA-PPS
COMB-ST330M-NW (07/24)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
Name(s) of your Child(ren) (First, Middle, Last)	**Date of Birth (MM/DD/YYYY)**	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you have additional children.

Smoking Status Information for Term Life Insurance

	Member	Spouse/Domestic Partner
Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

If you are changing smoking status

Status is changing from: ☐ Smoker to Non-Smoker ☐ Non-Smoker to Smoker Change is for: ☐ Member ☐ Spouse/Domestic Partner

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ADM
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GEF02-1
ADM *applies to residents of Connecticu*t, *North Dakota and Utah)*

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. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

	Member	Spouse/Domestic Partner
1. Member's height ___ feet ___ inches; Spouse/Domestic Partner ___ feet ___ inches		
Member's weight ____ pounds; Spouse/Domestic Partner weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes", indicate type: Member: _____ Spouse/Domestic Partner: _____	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ Yes ☐ No
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) Member: _____ Spouse/Domestic Partner: _____	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ Yes ☐ No
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐ Yes ☐ No	☐ Yes ☐ No
Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.		
10. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? **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), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No	☐ Yes ☐ No
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?	☐ Yes ☐ No	☐ Yes ☐ No
b. stroke or circulatory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
d. cancer, Hodgkins disease, lymphoma or tumors?	☐ Yes ☐ No	☐ Yes ☐ No
e. anemia, leukemia or other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No
f. diabetes? Member: Your age at diagnosis?: _____ ☐ Check if insulin treated Spouse/Domestic Partner: Your age at diagnosis? _____ ☐ Check if insulin treated	☐ Yes ☐ No	☐ Yes ☐ No
g. asthma, COPD, emphysema or other lung disease?	☐ Yes ☐ No	☐ Yes ☐ No
h. ulcers, stomach, hepatitis or other liver disorder?	☐ Yes ☐ No	☐ Yes ☐ No
i. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
j. memory loss?	☐ Yes ☐ No	☐ Yes ☐ No
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Member: Specify date of last seizure (month/year) _____ Indicate type _____ Spouse/Domestic Partner: Specify date of last seizure (month/year) _____ Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐ Yes ☐ No	☐ Yes ☐ No
m. multiple sclerosis, ALS or muscular dystrophy?	☐ Yes ☐ No	☐ Yes ☐ No
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐ Yes ☐ No	☐ Yes ☐ No
o. arthritis? Member: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____ Spouse/Domestic Partner: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐ Yes ☐ No	☐ Yes ☐ No
p. back, neck, knee, spinal, joint or other musculoskeletal disorder?	☐ Yes ☐ No	☐ Yes ☐ No
q. carpal tunnel syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
r. kidney, urinary tract or prostate disorder?	☐ Yes ☐ No	☐ Yes ☐ No
s. thyroid or other gland disorder?	☐ Yes ☐ No	☐ Yes ☐ No
t. mental, anxiety, depression, attempted suicide or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
u. sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No

MEMBER SECTION ONLY

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Member Name ______________________ Your Date of Birth __/__/______

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): ______________________

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): ______________________

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): ______________________

Medication: ______________________ Condition/Diagnosis: ______________________

Prescribing Physician's Name: ______________________ Telephone: (____) ____–______

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

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u 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.

Question Number	Condition/Diagnosis/Type	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/Type	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: (____) ____-_____

SPOUSE/DOMESTIC PARTNER SECTION ONLY
After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Spouse/Domestic Partner Name ______________________ Your Date of Birth __/__/__________

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): ______________________

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): ______________________

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): ______________________

Medication: ______________________ Condition/Diagnosis: ______________________
Prescribing Physician's Name: ______________________ Telephone: (____) ____–______
Address (Street, City, State, Zip Code): ______________________

SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u 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.

Question Number	Condition/Diagnosis/Type	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/Type	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 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 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.

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*;
GEF09-1
FW *applies to residents of Connecticut*, *North Dakota and Utah)*

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

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.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
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(S)

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I 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, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **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.
4. 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 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.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. 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)

Spouse/Domestic Partner

By signing below, I acknowledge:

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

Sign Here

Signature of Spouse/Domestic Partner	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 Connecticut, 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.

Payment Information

I am selecting the following payment option and am including (check one of the boxes below):

Select frequency of payment: ☐ Annual ☐ Semiannual ☐ Quarterly

Select method: ☐ Check ☐ A completed EFT authorization

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, LLC ("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;
  - 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, 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 Member		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Sign Here

Signature of Spouse/Domestic Partner		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

APPA/PPS-158966
AUTH-XDP110M-NW (06-24)