

Application for Life Insurance

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "the Company".
Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company

SECTION I - About the Proposed Insured

For Additional Insureds please complete the Additional Insureds Supplement form.

First Name Middle Name Last Name
Permanent Address City State Zip
Country of Legal Residence Date of Birth E-Mail Address
Primary Phone Number Alternate Phone Number Preferred Time to Call From To AM PM Sex Male Female
Place of Birth Social Security or Tax ID Number Earned Annual Income Net Worth
U.S. Driver's License Issuer of ID If not licensed, please indicate other form of ID: ID Number Issue Date (if any) Passport Issue Date (if any) Government Issued Photo ID Expiration Date (if any)
Name of Employer Employer City State Zip Position/Duties

NON U.S. CITIZENS ONLY - Country of Citizenship Green Card/Visa Type Expiration Date
Country of Permanent Residence ID Number Years in the U.S.

SECTION II - About the Owner

Complete ONLY if the Owner is NOT the Proposed Insured.

OWNER - TRUST / BUSINESS ENTITY - Name of Entity Tax ID Number Trustee / Owner State
Trust Business Entity Charity Qualified Pension Plan Complete the appropriate required form(s).
OWNER - OTHER INDIVIDUAL
First Name Middle Name Last Name
Permanent Address City State Zip
Country of Legal Residence Citizenship Social Security or Tax ID Number Date of Birth Phone Number
E-Mail Address Earned Annual Income Net Worth Relationship to Proposed Insured
Please indicate form of ID: U.S. Driver's License Issuer of ID ID Number Passport Issue Date (if any) Government Issued Photo ID Expiration Date (if any)
Check if ownership should revert to Insured upon Owner and Contingent Owner's deaths.



SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries, use Section IX - Additional Information.

Check here if the Owner is the Primary Beneficiary.

For Primary or Contingent Beneficiaries who are NOT the Owner, complete the table below.

| Beneficiary Type | Name (First, Middle, Last) | Date of Birth | Relationship to Proposed Insured | Social Security Number (Optional) | Percentage of Proceeds (if not equal) |
|---|----------------------------|---------------|----------------------------------|-----------------------------------|---------------------------------------|
| Primary | | | | | |
| <input type="checkbox"/> Primary <input type="checkbox"/> Contingent | | | | | |
| <input type="checkbox"/> Primary <input type="checkbox"/> Contingent | | | | | |

Check here to include all living and future natural or adopted children of the Proposed Insured as Contingent Beneficiaries. (Name all living children above.)

If a Custodian is acting on behalf of a minor Beneficiary listed above, please use **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

Federal law states that if someone with special needs has assets over \$2,000, they may lose eligibility for government benefits.

SECTION IV - About Proposed Coverage

Check the desired coverage(s).

| <input type="checkbox"/> Universal Life | <input type="checkbox"/> Variable Life <input type="checkbox"/> | <input type="checkbox"/> Whole Life | <input type="checkbox"/> Term Life |
|---|---|--|--|
| Product Name _____ | Product Name _____ | Product Name _____ | Product Name _____ |
| Face Amount* _____ | Face Amount* _____ | Face Amount* _____ | Face Amount* _____ |
| Riders and Details _____ | Riders and Details _____ | Riders and Details _____ | Riders and Details _____ |
| <input type="checkbox"/> Coverage Continuation (UL only) | <input type="checkbox"/> Disability Waiver | <input type="checkbox"/> Dividend Options: <input type="checkbox"/> Paid-Up Additions <input type="checkbox"/> Other, please specify: _____ | <input type="checkbox"/> Disability Waiver: <input type="checkbox"/> Convertible <input type="checkbox"/> Non-Convertible |
| Disability Waiver: <input type="checkbox"/> Specified Premium _____ <input type="checkbox"/> Monthly Deduction (VUL only) | <input type="checkbox"/> Automatic Premium Loan Requested | <input type="checkbox"/> For a full list of riders and options, please consult with your Producer. Note: Some riders may require supplement forms to be completed. <input type="checkbox"/> For Variable Life products, please complete the Variable Life Supplement form. * If Face Amount is equal to or exceeds \$1,000,000, please complete the Personal Financial Information form. | |
| Death Benefit Option _____ | | | |
| Definition of Life Insurance: <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test | | | |
| Planned Premium Year 1 _____ Years 2 to _____ Years ____ to ____ (UL only) | | | |

ADDITIONAL OPTIONS

One Time (Single) Payment Amount 1035 Exchange Amount Requested Policy Date Save Age

POLICY OPTIONS

Alternate Policy: Product, Face Amount and Details _____

Additional Policy: Product, Face Amount and Details _____

Group Conversion Only } Please complete the **Group Conversion Supplement** form for either choice.

Group Conversion Alternative



SECTION V - About Existing or Applied for Insurance

Does the Proposed Insured or Owner have any existing or applied for life insurance or annuities with this or any other company?

Proposed Insured Yes No
 Owner Yes No

If **YES**, please provide details of any existing or applied for **Life Insurance** on the **Proposed Insured only**.

| Company | Amount of Insurance | Year of Issue | Status |
|---------|---------------------|---------------|--|
| | | | <input type="checkbox"/> Existing <input type="checkbox"/> Applied For |
| | | | <input type="checkbox"/> Existing <input type="checkbox"/> Applied For |
| | | | <input type="checkbox"/> Existing <input type="checkbox"/> Applied For |
| | | | <input type="checkbox"/> Existing <input type="checkbox"/> Applied For |

In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? Yes No

If **YES**, complete **Replacement Questionnaire** AND any other state required replacement forms or 1035 exchange forms.

If Proposed Insured is financially dependent on another individual, indicate individual providing support:

Spouse Child Parent Other _____

Amount of insurance on individual providing support. Existing Insurance _____ Insurance Applied For _____

If Proposed Insured is a minor, are all siblings equally insured? Yes No

If **NO**, please provide details: _____

SECTION VI - About Payment Information

PREMIUM PAYOR

Proposed Insured Owner (If NOT the Proposed Insured.) Other (Complete the box below.)

| | | | |
|---------------------------------|----------------------------------|---|-----|
| Other Premium Payor Name | Social Security or Tax ID Number | Relationship to Proposed Insured or Owner | |
| Reason this Person is the Payor | | | |
| Permanent Address | City | State | Zip |


PAYMENT MODE (Check the appropriate ONE.) Billing Mode: Annual Semi-Annual Quarterly
 Monthly Draft per Debit Authorization (See next page.)
 Monthly Draft per Existing Electronic Payment Number _____

Special Account: Government Allotment Salary Deduction List Bill
 If Special Account, provide Employer Group Number (EGN) or List Bill Number _____

INITIAL PAYMENT Method of Collection:
 Amount Collected with Application _____ Initial Premium by Electronic Funds Transfer (Must be at least a monthly amount.)
 Check (Must be at least 1/12 of an annual premium.)

SOURCE OF CURRENT AND FUTURE PAYMENTS (Check **ALL** that apply.)
 Earned Income Mutual Fund/Brokerage Account Money Market Fund Savings Loans
 Certificate of Deposit Use of Values in another Life Insurance/Annuity Contract Other _____



DEBIT AUTHORIZATION  Available only if the bank account holder is the Owner and/or Proposed Insured.

 All others please complete the **Electronic Payment (EP) Account Agreement** form.

The undersigned ("I") hereby authorize the Company with whom I am completing this application to initiate debit entries through Metropolitan Life Insurance Company to the deposit account designated below, at the Financial Institution named below, using the Automated Clearing House. I authorize:

1. Monthly recurring debits; AND
2. Debits made from time to time, as I authorize.

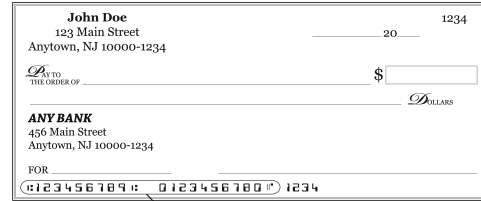
This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and the Financial Institution a reasonable opportunity to act on it.

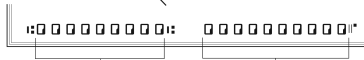
Monthly Debit Date: Issue Date of the Policy
 Debit Date on the _____ of each month

Bank Account Type: Checking Savings

Bank Routing Number _____ Bank Account Number _____

Name of Financial Institution _____




 BANK ROUTING NUMBER BANK ACCOUNT NUMBER

 Note: Please attach a voided check or deposit slip to Section IX - Additional Information.

We cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services from foreign banks UNLESS the check is being paid in U.S. Dollars through a U.S. correspondent bank (the U.S. correspondent bank name must be on the check).

SECTION VII - General Risk Questions

Use Section IX - Additional Information if necessary.

1. Within the past three years has the Proposed Insured flown in a plane other than as a passenger on a commercial airline or does he or she have plans for such activity within the next year? Yes No

 If **YES**, please complete a separate **Aviation Risk Supplement** form for the Proposed Insured.

2. Within the past three years has the Proposed Insured participated in or does he or she plan to participate in **any** of the following? Yes No

- Underwater sports - SCUBA diving, skin diving, or similar activities
- Racing sports - motorcycle, auto, motor boat or similar activities
- Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities
- Rock or mountain climbing or similar activities
- Bungee jumping or similar activities

 If **YES**, please complete a separate **Avocation Risk Supplement** form for the Proposed Insured.

3. Has the Proposed Insured **traveled** or **resided** outside the U.S. or Canada within the **past two years**; or does he or she plan to **travel** or **reside** outside the U.S or Canada within the **next two years**? Yes No

If **YES**, please provide details.

| Past | Future | Duration (weeks) | Cities and Countries | Purpose |
|--------------------------|--------------------------|------------------|----------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | |

4. Has the Proposed Insured **EVER** used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)? If **YES**, please provide details. Yes No

| Product(s) | Frequency / Amount | Date Last Used |
|------------|--------------------|----------------|
| | | |



5. Has the Proposed Insured **EVER** had a driver's license suspended or revoked, been convicted of DUI or DWI, or in the last five years had any moving violations? If **YES**, please provide date(s) and violation(s). Yes No

6. Has the Proposed Insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? If **YES**, please provide details. Yes No

7. In the past 10 years, has the Proposed Insured been convicted of or pled Guilty or No Contest to a felony? Yes No
If **YES**, list type of felony, state, and date of occurrence. _____

8. Is the Proposed Insured actively at work performing the usual duties of his or her occupation? Yes No
If **NO**, please provide details. _____

SECTION VIII - Personal Physician

Check here if Proposed Insured does not have a personal physician.

| | | | | |
|----------------------|---------------------------|----------------------------------|--|-----------|
| Physician Name _____ | | Name of Practice or Clinic _____ | | |
| Street Address _____ | | City _____ | State _____ | Zip _____ |
| Phone Number _____ | Date Last Consulted _____ | Reason _____ | Findings/Treatment Given/Medication Prescribed _____ | |

SECTION IX - Additional Information

If more space is needed, attach additional sheet(s).



Certification / Agreement / Disclosure

Was a sales illustration provided for the life insurance policy as applied for?

Yes No

A. If **Yes**, please choose one of the following:

- An illustration was signed and **matches the policy applied for**. It is included with this application.
- An illustration was shown or provided but is **different from the policy applied for**. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- The sale was made using an illustration with Accelerated Payment.
- If illustration was **only shown on a computer screen**, check and complete the details in the box below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) Male Female Unisex
2. Age _____
3. Rating Class (e.g. Standard Non-smoker) _____ Non-smoker Smoker
4. Product Name (e.g. GAUL) _____
5. Face Amount _____
6. Dividend Option (Whole Life only) _____

B. If **No**, please choose one of the following:

- Producer certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.
- No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Agreement / Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application, paramedical/medical exam, amendment(s), or any supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**
- **If I was required to sign a Notice and Consent for HIV Testing, I have received a copy of that Notice.**



Fraud Warnings

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma, Rhode Island

Any person who knowingly and with intent to defraud any insurance company or any 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.

District of Columbia, Tennessee, Virginia, 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 denial of insurance benefits.

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

- The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
 - (a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **or**
 - (b) the IRS has notified me that I am not subject to backup withholding.
(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)
- I am a U.S. citizen or a U.S. resident alien for tax purposes.
(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

❶ **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signatures

If not witnessing all signatures, witness should initial next to signature being witnessed and sign below.

| | | |
|---|-------|-----------------------|
| Signature(s) of all Proposed Insured(s) | Date | Signed at City, State |
| ▶ _____ | _____ | _____ |

| | | |
|---------|-------|-------|
| ▶ _____ | _____ | _____ |
|---------|-------|-------|

(age 15 or over)

📄 Please complete the **Additional Insureds Supplement** or **Child Rider Supplement** form(s) if applicable.

| | | |
|--|-------|-----------------------|
| Signature(s) of all Owner(s) (If NOT the Proposed Insured.) | Date | Signed at City, State |
| ▶ _____ | _____ | _____ |

| | | |
|---------|-------|-------|
| ▶ _____ | _____ | _____ |
|---------|-------|-------|

(age 15 or over)

❶ If the Owner is a firm or corporation, include Officer's title with signature.

📄 If Co-Owner or Custodian, please complete the **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

| | | |
|---------------------------------|-------|-----------------------|
| Signature of Parent or Guardian | Date | Signed at City, State |
| ▶ _____ | _____ | _____ |

(If Owner or Proposed Insured is under 18, sign here. If not sign above.)

Witness to Signatures

| | |
|-------------------|------------------------|
| Licensed Producer | Print Name of Producer |
| ▶ _____ | _____ |



Authorization

Company (Check the appropriate ONE.) Metropolitan Life Insurance Company General American Life Insurance Company
The Company indicated in this section is referred to as "**the Company**". New England Life Insurance Company MetLife Investors USA Insurance Company
 MetLife Investors Insurance Company Metropolitan Tower Life Insurance Company

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any pharmacy or pharmacy-related service organization; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
 - personal information and data;
 - entire medical file for the last ten (10) years, including medical information, records and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
 - information related to alcohol and drug abuse and treatment;
 - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the Company as described in the Company's Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor

who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.

- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. Health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization cannot condition treatment or payment for treatment or other benefits on my signing it.
- **This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company, Privacy Office, PO BOX 489, Warwick, RI 02887-9954 and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.**
- **I have a right to receive a copy of this form.**
- **A photocopy of this form is as valid as the original form.**

Signatures

Print Name of Proposed Insured

Date of Birth

First

Middle

Last

If Proposed Insured is under 18, the **Parent** or **Guardian** is to sign on line for such child.

Signature of Proposed Insured

Date

Signed at City, State

As witness, I attest to having observed all parties sign in my presence.

Witness to Signature



Notice and Consent For HIV-Related Testing

Company Copy

- Company (Check the appropriate ONE.) [] Metropolitan Life Insurance Company [] General American Life Insurance Company
The Company indicated in this section is referred to as "the Insurer". [] New England Life Insurance Company [] MetLife Investors USA Insurance Company
[] MetLife Investors Insurance Company [] Metropolitan Tower Life Insurance Company

THE HIV VIRUS AND AIDS

To evaluate your insurability, it is requested that you provide a blood or other bodily fluid sample for testing for the presence of HIV antibodies or antigens, as well as for other tests such as cholesterol, diabetes and immune disorders.

- b. False negatives: the test may give a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least four to 12 weeks for a positive test result to develop after a person is infected.

MEANING OF POSITIVE HIV TEST RESULT

A positive HIV test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system including AIDS or AIDS-related conditions.

COUNSELING/ANONYMOUS TESTING

Many public health organizations have recommended that before submitting to an HIV test, a person seek counseling to better understand the implications of the test.

SIDE EFFECTS

A positive HIV test result may cause you significant anxiety, and may also result in uninsurability for life, health, or disability insurance policies you may apply for now or in the future.

See reverse side for counseling information. For your information, HIV is transmitted: by sexual contact with an infected person; from an infected mother to her newborn infant; or by exposure to infected blood (as in needle sharing during intravenous drug use).

CONFIDENTIALITY

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed: to the proposed insured (unless state law requires disclosure only to a physician; see Notification section); to the person legally authorized to consent to the test; to a licensed physician, medical practitioner, or other person designated by the proposed insured; if your HIV test is other than normal, to the Medical Information Bureau (MIB), a national insurance data bank, using a non-specific code, indicating only an abnormal test, to assure confidentiality; for statistical reports that do not disclose the identity of any particular proposed insured; to employees, reinsurers, or contractors of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer; and to Insurer's legal counsel who needs such information to represent the Insurer effectively in matters concerning the proposed insured.

THE TEST: PURPOSE AND ACCURACY

The HIV antibody test is a medically accepted three-test series which is extremely accurate and reliable and is performed by a licensed laboratory. It is not error free. Possible errors include:

- a. False positives: the test may give a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.



NOTIFICATION

If your test results are negative, no routine notification will be sent to you unless you complete the following:

Name to whom to disclose negative test results:

Address:

If your HIV test results are other than normal, you or a person you designate may receive the results directly except in states that prohibit direct notification (see list below). In states that prohibit direct notification, if you do not name a physician, the Insurer must notify the health department who will then notify you. It is recommended that you designate a physician, health department, or local organization (see reverse side) to receive the test result because a trained person should deliver the information so that you can understand the meaning of the test result.

Physician, health department, or organization for reporting a positive test result:

Address:

PREVENTION

Persons who have a history of high-risk behavior should modify these behaviors to prevent getting or giving AIDS, regardless of whether or not they are tested. Specific important changes in behavior include safe sex practices (including latex condom use) and not sharing needles.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above in the Confidentiality and Notification sections.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent is valid for six months from the date signed unless revoked by me in writing. A revocation will not affect disclosures already made, but no further disclosure will be made thereafter without my express written consent.

Name of Proposed Insured (Please Print)

First

Middle

Last

Signature of Proposed Insured or Parent/Guardian

Date

► _____

Witness



Producer Identification & Certification

⚠ Incomplete information may delay your application.

1. What is the purpose of insurance? (Check **ALL** that apply.)

| | | | | |
|---|--|---|--|-------------------------------------|
| <input type="checkbox"/> Estate Planning | <input type="checkbox"/> Charitable Giving | <input type="checkbox"/> Qualified Plan | <input type="checkbox"/> Mortgage Protection | <input type="checkbox"/> Buy/Sell |
| <input type="checkbox"/> Executive Bonus | <input type="checkbox"/> Split Dollar | <input type="checkbox"/> Private Split Dollar | <input type="checkbox"/> Deferred Compensation | <input type="checkbox"/> Key Person |
| <input type="checkbox"/> Business Needs - Other | <input type="checkbox"/> Income Protection | <input type="checkbox"/> Other _____ | | |
2. Method used to arrive at the Face Amount Recommendation?

| | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Profiles Needs Analysis | <input type="checkbox"/> Human Life Value | <input type="checkbox"/> GSIB Proposal | <input type="checkbox"/> Other _____ |
|--|---|--|--------------------------------------|
3. Was this sale made using an illustration with Accelerated Premium? If **YES**, please indicate number of years.

| | | |
|------------------------------|------------|-----------------------------|
| <input type="checkbox"/> Yes | _____ yrs. | <input type="checkbox"/> No |
|------------------------------|------------|-----------------------------|
4. Is this insurance a replacement?

| | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|
5. Have you completed and attached the required replacement forms?

| | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|
6. Have you attached the Internal Revenue Code Section 1035 form?

| | | |
|------------------------------|-----------------------------|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
|------------------------------|-----------------------------|------------------------------|
7. Have the following documents been delivered:

| | | | | | | | |
|---------------------------------|------------------------------|-----------------------------|------------------------------|---|------------------------------|-----------------------------|------------------------------|
| Privacy Notice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Life Insurance Buyer's Guide | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| HIV Notice and Consent Form | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Temporary Insurance Agreement and Receipt | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Compensation Disclosure Notice* | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Military Disclosure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| Debit Authorization Disclosure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | Current prospectus for variable products and riders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A |
| ABR/ADBR Disclosure Statement | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> N/A | | | | |

*Only required for business sold by Agency Distribution Group (MetLife and NEF), MLR and MetLife Auto & Home sales representatives.

8. Did you use only sales material approved for use by the appropriate Company?

| | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|
9. Did you see all persons to be insured on the date the application was taken?

| | | |
|------------------------------|-----------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If NO , why not? _____ |
|------------------------------|-----------------------------|-------------------------------|
10. Do any of the Beneficiaries (Primary or Contingent) or their dependents have special needs?

| | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|
11. Are you related to the Proposed Insured(s)?

| | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If YES , indicate relationship _____ |
|------------------------------|-----------------------------|---|
12. Are the Proposed Insured(s) and Owner(s) interested in electronic delivery of product reports?

| | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

Certification of Owner Identity:

- I certify that I personally met with the Owner(s)/legal representative(s) of the entity and reviewed the appropriate identification documents. To the best of my knowledge the documents accurately reflect the identity of the Owner(s)/legal representatives of the entity.
- I did not meet in person with the Owner(s)/legal representative(s) of the entity or I was otherwise unable to personally review the Owner(s)/entity's identification documents. I certify that, to the best of my knowledge, the Owner(s)/entity's identification information provided by the legal representative(s) either by mail or phone is accurate.

I certify that I have truly and accurately recorded on all parts of this application the information supplied by the Proposed Insured(s) and/or the applicant(s). As noted in question #9 above, I have personally observed each Proposed Insured and applicant. Apart from any admissions recorded on the application or any additional comments that I have supplied to underwriting, each appears to me to be healthy. The purpose of this sale has been discussed with the Owner(s) and I believe this application to be an appropriate recommendation.

| Producer Name (Please Print FULL Name) | Sales Office/ Agency Number/ID | Producer Number/ID | Commission Split % 1st Year Renewal | Amount of GDC (for MLD only) |
|---|-----------------------------------|-----------------------|---|---------------------------------|
| | | | | |
| | | | | |
| | | | | |

Signatures

Name of Producer _____ **Producer Signature** _____ **Date** _____

I have personally reviewed this application for appropriateness of sale. The Producer was appropriately licensed and appointed on the date the application was signed.

Name of Agency Manager or Designee _____ **Agency Manager or Designee Signature** _____ **Date** _____

Broker/Dealer or Home Office use only _____ **Registered Principal Signature** _____ **Date** _____
 Suitability Review of Variable Products

Annualized Commissions - Life Independent Producers ONLY Does the Producer wish to annualize commissions? Yes No

If **YES**, signature of Producer's Manager (GA/MGA/BGA) is required. _____ **GA/MGA/BGA Signature** _____ **Date** _____



Personal Financial Information

⚠ To be completed when the amount of coverage is \$1,000,000 and over

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- Metropolitan Life Insurance Company
- New England Life Insurance Company
- MetLife Investors Insurance Company
- General American Life Insurance Company
- MetLife Investors USA Insurance Company
- Metropolitan Tower Life Insurance Company

SECTION I - Income

Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw \$ _____
 Bonus/Commissions \$ _____
 Other Earnings \$ _____
 Source _____

Total Earned Income \$ _____

Spouse's Income \$ _____

Annual Unearned Income (in US dollars)

Dividends/Interest \$ _____
 Net Rentals \$ _____
 Other Unearned \$ _____
 Source _____

Total Unearned Income \$ _____

Additional Proposed Insured

First Name _____ Last Name _____

Annual Earned Income (in US dollars)

Salary or Draw \$ _____
 Bonus/Commissions \$ _____
 Other Earnings \$ _____
 Source _____

Total Earned Income \$ _____

Spouse's Income \$ _____

Annual Unearned Income (in US dollars)

Dividends/Interest \$ _____
 Net Rentals \$ _____
 Other Unearned \$ _____
 Source _____

Total Unearned Income \$ _____

SECTION II - Assets and Liabilities

Proposed Insured

Assets (in US dollars)

Cash \$ _____
 Real Estate \$ _____
 Business Equity \$ _____
 Stocks/Bonds \$ _____
 Other Assets \$ _____

Total Assets \$ _____

Liabilities (in US dollars)

Mortgages \$ _____
 Personal Loans \$ _____
 Other \$ _____

Total Liabilities \$ _____

Net Worth \$ _____

(Total Assets - Total Liabilities)

Additional Proposed Insured

Assets (in US dollars)

Cash \$ _____
 Real Estate \$ _____
 Business Equity \$ _____
 Stocks/Bonds \$ _____
 Other Assets \$ _____

Total Assets \$ _____

Liabilities (in US dollars)

Mortgages \$ _____
 Personal Loans \$ _____
 Other \$ _____

Total Liabilities \$ _____

Net Worth \$ _____

(Total Assets - Total Liabilities)



Medical Supplement

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "the Company".
Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company

This supplement will be attached to and become part of the application with which it is used.

SECTION I - Medical Questions
If more space is needed, attach additional sheet(s).

If FULL PARAMEDICAL/MEDICAL EXAM is required, completion of this Medical Supplement form is OPTIONAL.

Proposed Insured - First Name Middle Name Last Name

1. Please provide Proposed Insured's height and weight: Height (ft. in.) Weight (lbs.)
Has the Proposed Insured experienced a change in weight greater than 10 pounds in the past 12 months?
If YES, please specify: Pounds Lost Pounds Gained Reason

2. Has the Proposed Insured EVER been diagnosed, received treatment, or consulted with a health professional for any of the following? If YES, please check ALL that apply and provide details in table below.

- A. High Blood Pressure B. Chest Pain C. Heart Attack D. Heart Murmur E. Diabetes F. High Cholesterol G. Cancer / Tumor / Polyp
H. Asthma / Bronchitis I. Emphysema J. Sleep Apnea K. Seizures L. Stroke / TIA M. Paralysis N. Multiple Sclerosis
O. Parkinson's Disease P. Alzheimer's Disease Q. Memory Loss R. Colitis S. Cirrhosis T. Hepatitis U. Arthritis
V. Lupus W. Anemia X. Depression / Anxiety Y. Eating Disorder

Table with 4 columns: Letter, Name of Health Professional (Include City & State), Date / Duration of Illness, Diagnosis / Treatment / Medication

3. Other than as indicated above, has the Proposed Insured EVER had any disease or disorder of any of the following? If YES, please check ALL that apply and provide details in table below.

- A. Heart B. Arteries / Veins C. Lungs / Respiratory System D. Gastrointestinal / Digestive System E. Liver / Pancreas F. Kidney / Bladder
G. Prostate H. Reproductive Organs I. Brain / Nervous System J. Blood K. Lymph Nodes L. Immune System
M. Thyroid / Other Glands N. Eyes O. Ears / Nose / Throat P. Skin Q. Muscles / Bones / Joints R. Emotional / Psychological Disorder

Table with 4 columns: Letter, Name of Health Professional (Include City & State), Date / Duration of Illness, Diagnosis / Treatment / Medication



4. Other than as indicated previously, within the past five years, has the Proposed Insured had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility? Yes No
5. Is the Proposed Insured currently receiving any treatment or taking any prescription or nonprescription medications or supplements? Yes No
6. Does the Proposed Insured have any surgery, medical tests, treatment or visits with a health professional scheduled in the next six months? Yes No
7. Has the Proposed Insured ever been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
8. Has the Proposed Insured ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus? Yes No
9. Has the Proposed Insured ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health professional? Yes No
10. Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health professional or support group? Yes No

If **YES**, please provide details in table below for Questions 4 - 10.

| Number | Name of Health Professional (Include City & State) | Date / Duration of Illness | Diagnosis / Treatment / Medication |
|--------|---|----------------------------|------------------------------------|
| | | | |
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SECTION II - Family History

Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer; or kidney disease? If **YES**, please provide details in table below. Yes No

| Relationship to Proposed Insured | Age(s) if Living | Age(s) at Death | State of Health (Specific Conditions) or Cause of Death |
|----------------------------------|------------------|-----------------|---|
| Father | | | |
| Mother | | | |
| Sibling | | | |
| Sibling | | | |
| Sibling | | | |



Privacy Notice

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- | | |
|--|--|
| <input type="checkbox"/> Metropolitan Life Insurance Company | <input type="checkbox"/> General American Life Insurance Company |
| <input type="checkbox"/> New England Life Insurance Company | <input type="checkbox"/> MetLife Investors USA Insurance Company |
| <input type="checkbox"/> MetLife Investors Insurance Company | <input type="checkbox"/> Metropolitan Tower Life Insurance Company |

SECTION I - Introduction

i This notice is given to you on behalf of the Company.

Thank you for your application. Now we will review what you told us and may get further information if needed.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.)

SECTION II - Why We Need Information

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

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

SECTION III - How We Get Information

What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some sources may give us reports and may disclose what they know to others. 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.

This will help us decide if you are eligible for insurance from us and what we should charge for it. For example, anyone who has used nicotine in any form within the last year will not be eligible for our lowest premium rate.

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

If we ask an agency for an "investigative" report about you - which means that they will ask others about you - we will ask them to contact you as well. 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, Massachusetts 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.

SECTION IV - How We Protect Information

Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have.

SECTION V - How We Use and Disclose Information

We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you.
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Help us comply with the law

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services.

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

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena;
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company;
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for;
- Telling your health care provider about a medical problem that you have but may not be aware of;
- Giving your information to a peer review organization if you have health insurance with us; and
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy.

We may use what we know about you in order to offer you our other products and services. We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our own products and services to you. In addition, we can tell you about our affiliates and the products they offer.

Unless you tell us not to share information after receiving an "opt out" notice (see "**How You Can Make an 'Opt Out' Election**" below), we may disclose certain information to our affiliates so that they can offer their products and services directly to you. Even if you do not "opt out," we will not disclose your health information to another company to permit it to market its products to you. We will also not share your information with other unaffiliated companies who may want to market their products directly to you, unless it is in connection with a joint marketing arrangement (as described below). We will not sell or otherwise disclose your information to, for example, a catalog company. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses. In addition, if we have joint marketing agreements with other unaffiliated companies, we may give them information about you so that we can offer products to you jointly or so they can offer products and services endorsed or sponsored by us to you. But we will not share information for joint marketing if you tell us not to or if the law that applies to you does not allow it.

How You Can Make an "Opt Out" Election: You can tell us not to share your information to let our affiliates market their products directly to you, or not to disclose your information to a third party in connection with a joint marketing arrangement. An "opt-out" election form will be provided to you at the time the policy is issued.

SECTION VI - How You Can See And Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside MetLife.

SECTION VII - You Can Get Other Material From Us

In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to the company you applied to, c/o MetLife Privacy Office, P. O. Box 489, Warwick, Rhode Island 02887-9954.

Life Insurance Buyer's Guide

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Insurer**".

- | | |
|--|--|
| <input type="checkbox"/> Metropolitan Life Insurance Company | <input type="checkbox"/> General American Life Insurance Company |
| <input type="checkbox"/> New England Life Insurance Company | <input type="checkbox"/> MetLife Investors USA Insurance Company |
| <input type="checkbox"/> MetLife Investors Insurance Company | |

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. This guide does not endorse any company or policy.

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need and for how long and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you. Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.

- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

Life Insurance Buyer's Guide

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?.
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?

- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the new policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced

amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and study it carefully. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Buyer's Guide

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the

company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will also be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider.

For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies those that offer basically the same benefits, with premiums payable for the same length of time.

One type of index, called the life insurance yield comparison index, is a measure of cash value growth over the index period which takes into account the interest credited, the estimated value of the death protection provided, and the expenses charged. A higher yield index number generally indicates a better buy. Since this index reflects items other than interest earnings, it may differ from the credited interest rate advertised or guaranteed in your policy. For the same reason, the yield index will differ substantially from the return on a pure investment like a savings account. Keep this in mind if you attempt to compare yield indexes with investment returns.

Another type of index, the net payment cost comparison index helps you compare costs over a 10 or 20 year period assuming you will continue to pay premiums on your policy and do not take its cash value. It is useful if your main concern is the benefits that are to be paid at your death.

The most important thing to remember is that, when using the net payment cost comparison index, a policy with smaller index numbers is generally a better buy than a similar policy with larger

index numbers. When using the life insurance yield comparison index, the opposite is true: a policy with larger yield comparison index numbers is generally a better buy than one with smaller yield comparison index numbers.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Reprinted by MetLife

Temporary Insurance Agreement and Receipt

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- | | |
|--|--|
| <input type="checkbox"/> Metropolitan Life Insurance Company | <input type="checkbox"/> General American Life Insurance Company |
| <input type="checkbox"/> New England Life Insurance Company | <input type="checkbox"/> MetLife Investors USA Insurance Company |
| <input type="checkbox"/> MetLife Investors Insurance Company | |

SECTION I - What Does Temporary Insurance Provide?

For those eligible, Temporary Insurance provides for a death benefit upon receipt of proof of death of the Proposed Insured(s). The Temporary Insurance death benefit will be for the amount of insurance (including riders) applied for on the life of the deceased Proposed Insured(s) named on the application bearing the date of this Receipt and the supplement(s) to that application (collectively the "Application"). The total death benefit under this Receipt and all other receipts issued by all the companies listed above will not be more than \$1,000,000 for any Proposed Insured(s) (\$2,000,000 for survivorship life policies).^{*} However, there will be no death benefit provided for the first death on a survivorship policy, or if death is by suicide. The death benefit will be paid to the person who would have received payment under the policy, had it been issued.

If the health or insurability of the Proposed Insured(s) changes once Temporary Insurance has started, the Company will consider the health of the Proposed Insured(s) as of the date Temporary Insurance began in deciding whether to issue the policy applied for. If the Proposed Insured(s) should have a material change in health or insurability while Temporary Insurance is in effect, the total amount of insurance which may be issued under this Receipt and all other receipts will not be more than \$1,000,000 (\$2,000,000 for survivorship life policies).^{*}

If there is a person to be insured under an applicant waiver of premium rider or benefit (an "Applicant"), this benefit or rider will be included in the policy issued on the life of the Proposed Insured(s) if an Applicant dies: 1. Other than by suicide; 2. Before the rider or benefit is declined by the Company; and 3. While Temporary Insurance is in effect on the life of the Proposed Insured(s). Premiums under the policy will be waived under the terms of the rider or benefit applied for.

^{*}Should there be more than one application or receipt for any person to be insured, the share for each application will be in the ratio that the amount applied for on that application bears to the total amount of insurance applied for under all such applications.

SECTION II - Who is Eligible for Temporary Insurance?

The Proposed Insured(s) under the policy applied for is/are eligible for Temporary Insurance, if EACH of the following is true:

1. The Application, its supplements and paramedical/medical exam; do not include any material misrepresentation. AND
2. The Proposed Insured(s) has/have never received medical treatment from any physician, practitioner or health facility for or been diagnosed by any physician, practitioner or health facility as having: cancer; Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); coronary artery disease; stroke; alcohol use; drug use. AND
3. The Proposed Insured(s) is/are at least 14 days old.

SECTION III - When Does Temporary Insurance Start?

Coverage starts on the later of the date of this Receipt or (if required at the time the Application was completed by the Company's underwriting rules) the date of any medical examination of the Proposed Insured(s) provided that one of the following is satisfied on the date of the Application:

1. Payment by check of an amount of at least 1/12 of an annual premium; or
2. Payment of Initial Premium Draft per Electronic Funds Transfer; or
3. Properly completed MetLife salary deduction plan form(s); or
4. Properly completed government allotment form(s); or
5. If the life insurance applied for with the Application is to be part of a Qualified Plan under the Employee Retirement Income Security Act of 1974 "ERISA" (e.g. a Pension Plan, Profit Sharing Plan, or a 401(k) Plan) and the Proposed Owner is the trustee of the Qualified Plan and the Employer Group Number (EGN) assigned by the Company is entered in the appropriate space on the Application, and a copy of the Commission Disclosure forms is provided to the Proposed Owner.

If a check or draft is returned for insufficient funds it will not constitute payment and Temporary Insurance will not be in effect.

Temporary Insurance will be in effect, if it has not already ended under the terms of this Receipt, if a Proposed Insured dies: from an accident; within 30 days from the date of this Receipt; before the required medical exam described above is completed; and one of the above 5 items was received on the date of the Application.



SECTION IV - When Does Temporary Insurance End?

Temporary Insurance will end on the earliest of the following:

1. When coverage under a policy issued by the Company as a result of the Application takes effect.
2. When a policy issued by the Company as a result of the Application is not accepted.
3. When the Company offers to refund any payment received under this Receipt.
4. When the Company refunds any payment received under this Receipt.
5. The date the Proposed Insured(s) or an Applicant learns that either the Application has been declined or the Company has decided to terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
6. If the Application is for a Qualified Plan under ERISA, the Proposed Owner learns that either the Application has been declined or the Company has decided to terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
7. One hundred and twenty (120) days from the date of this Receipt.

If no policy takes effect, any payment received will be refunded when Temporary Insurance ends.

SECTION V - Limitations on Authority

No one but the President, Vice-President or the Secretary of the Company may change or waive the terms of this Receipt.

Signatures

All Premium Checks must be made payable to the Company checked on top of page 1.

DO NOT MAKE CHECK PAYABLE TO THE INSURANCE PRODUCER. DO NOT LEAVE THE CHECK PAYEE BLANK.

Amount Collected

Method of Collection:

- Check (Must be at least 1/12 of an annual premium.)
- Initial Premium by Debit Authorization in application (Must be at least a monthly amount.)
- Initial Premium by EP Account Agreement form (Must be at least a monthly amount.)
- MetLife Salary Deduction Plan form(s)
- Government Allotment form(s)
- Qualified Plan form(s)

Or receipt of:

is acknowledged in connection with the Application made on this date in which the Proposed Insured(s) is/are: _____

and the plan of insurance is: _____ from _____ company

Receipt Date: _____ Title: _____ Sales Office: _____

► Producer Signature: _____

Date _____ Signed at City, State _____

Metropolitan Life Insurance Company
New York, NY 10166



Gwenn L. Carr, Senior Vice-President and Secretary

New England Life Insurance Company
Boston, MA 02116



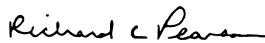
Daniel D. Jordan, Vice-President and Secretary

General American Life Insurance Company
St. Louis, MO 63128



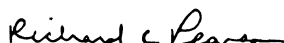
Daniel D. Jordan, Vice-President and Secretary

MetLife Investors USA Insurance Company
Wilmington, DE 19899



Richard C. Pearson, Executive Vice-President

MetLife Investors Insurance Company
St. Louis, MO 63128



Richard C. Pearson, Executive Vice-President

Note: If you have not heard from the Company within 120 days from the date of this Receipt, please contact the Company's representative.



Bank Draft Disclosure

SECTION I: Automatic Withdrawals

- Recurring withdrawals will not start unless the policy/contract is in force.
- All withdrawals authorized will appear on your bank statement as "MetLife" or "MET-PAC."
- If the payment withdrawal date selected falls on a weekend, a holiday, or, in a shorter month, if the date selected is 29-31, the account will be billed on the next business day.
- By authorizing automatic withdrawals, MetLife established a MetLife Electronic Payment Account ("EP Account") for you. The EP Account is a payment method available to pay for policies/contracts issued or sold by MetLife companies. Once you have an EP Account, other MetLife products can be included with this account so that payments can be withdrawn on the same date.

SECTION II: Multiple Payment Withdrawals

Multiple payments may be withdrawn when:

- More than one policy/contract payment is due or needed to bring your policy/contract up to date.
- You requested a life insurance policy be back-dated resulting in more than one payment due at time of issue.
- The withdrawal date selected is after the contract date for life insurance policies with flexible premiums.

Note: Guarantees may be affected if payments are missed or delayed.

SECTION III: Initial Premium Advance Payment for Life Insurance

This option will allow the advance payment to be withdrawn immediately at signing of an application or during the underwriting process for life insurance. This option is available if the policy/contract applied for will be paid by recurring monthly withdrawal. The initial withdrawal is subject to the terms of the Temporary Insurance Agreement and Receipt.

SECTION IV: Ending the Withdrawal

The EP Account shall remain in full force and effect until one of the following occurs:

- You notify MetLife of the termination of the EP Account. MetLife requires notification of at least 2 business days (5 business days for MetLife of Connecticut policies) before a scheduled payment to either terminate the EP or to prevent a scheduled payment.
- MetLife notifies you of the termination of the EP Account.
- The policy(ies)/contract(s) is/are no longer in effect.
- The bank account used for withdrawals is closed or is otherwise terminated.

SECTION V: General Information

If you change your bank or the bank account that you use for monthly deductions, you must stop your current agreement and complete a new form.

- If you are not able to submit the new EP Agreement form in advance of the previously authorized draft date, please be sure to leave sufficient funds in your original account to cover the deduction for that month.
- To obtain a new form refer to contact information below.

Paying insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.

Please be sure to have adequate funds in your bank account to cover the total monthly deduction on the Debit Authorization Form.

- If there are inadequate funds, your payment(s) into the policy(ies)/contract(s) may not be made, or may be made late. Either situation could result in a life insurance policy losing certain guarantees or lapsing.
- Please note that many banks charge their customer when there are inadequate funds for an electronic draft.

Based on the policy/contract, premiums can increase.

Should a policy/contract no longer be paid by electronic draft, premiums or payments will be payable at the most frequent mode of payment available for that policy/contract.

MetLife will not consider refund requests until ten business days after the withdrawal.

If your mailing address changes, or if you want to determine the status of your policy and any guarantees, please contact your representative or call us at 1-800-METLIFE (1-800-638-5433).



Acceleration of Death Benefit Rider (ADBR) Summary and Disclosure Statement

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- Metropolitan Life Insurance Company General American Life Insurance Company
 New England Life Insurance Company MetLife Investors USA Insurance Company

This accelerated life benefit does not and is not intended to qualify as long-term care under the Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

This Summary and Disclosure Statement gives a brief description of the important features of the Rider. This is not an insurance contract and only the actual provisions of the Rider will control. The Rider itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, very important that you READ THE RIDER CAREFULLY.

TAX CONSEQUENCES

In general, the receipt of benefits under the Rider is not subject to Federal income tax. You should consult a personal tax advisor to see how many benefits will be treated based on your specific facts and circumstances.

IF YOU RECEIVE PAYMENT OF ACCELERATED BENEFITS FROM A LIFE INSURANCE POLICY, YOU MAY LOSE YOUR RIGHT TO RECEIVE CERTAIN PUBLIC FUNDS, SUCH AS MEDICARE, MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY, SUPPLEMENTAL SECURITY INCOME (SSI), AND POSSIBLY OTHERS. ALSO, RECEIVING ACCELERATED BENEFITS FROM A LIFE INSURANCE POLICY MAY HAVE TAX CONSEQUENCES FOR YOU. WE CANNOT GIVE YOU ADVICE ABOUT THIS. YOU MAY WISH TO OBTAIN ADVICE FROM A TAX PROFESSIONAL, AN ATTORNEY AND/OR THE APPROPRIATE SOCIAL SERVICES AGENCY BEFORE YOU DECIDE TO RECEIVE ACCELERATED BENEFITS FROM A LIFE INSURANCE POLICY.

AVAILABILITY

An Accelerated Death Benefit is available if the Insured is terminally ill, subject to the terms of the Rider. The Rider provides for the partial or full acceleration of the Eligible Proceeds of the Policy.

ELIGIBLE PROCEEDS

Eligible Proceeds equal: the Policy proceeds as defined in the Policy; less any face amount provided by a Supplemental Coverage Term Rider; plus any amount of benefit provided by a rider that we consent to apply to an Accelerated Death Benefit. Eligible Proceeds will be calculated as of the date we receive a request for the Accelerated Death Benefit.

AMOUNT OF ACCELERATED DEATH BENEFIT

We will compute the Accelerated Death Benefit based on the following:

1. The amount of Eligible Proceeds you choose to accelerate;
2. Reduced life expectancy;
3. A processing charge not to exceed \$150; and
4. An Interest Rate no greater than the greater of:
 - a. The current yield on 90 day treasury bills; and
 - b. The current maximum statutory adjustable policy loan interest rate.

PAYMENT OF AN ACCELERATED DEATH BENEFIT

Unless otherwise requested, we will pay the Accelerated Death Benefit in one sum or by placing the amount in an account that earns interest. The Owner will have immediate access to all or any part of the account.

EFFECT OF ACCELERATION

If **part** of the Eligible Proceeds are applied to the Accelerated Death Benefit, any policy values and the death benefit on the remaining policy will be reduced proportionately. We will provide full disclosure of the effects of the acceleration on the policy's cash value if any, death benefit, premiums, policy loans if available and face amount.

If **all** of the Eligible Proceeds are applied to the Accelerated Death Benefit, all policy benefits based on the Insured's life, except for any benefit for accidental death, will end. Any accidental death benefit will continue in force under the conditions stated in the Rider. Any riders that provide a benefit on the life of someone other than the Insured will stay in effect pursuant to their terms as if the Insured had died. No further cost for those riders will be payable.

SAMPLE ILLUSTRATION

The chart below is a generic example of how an accelerated payment might affect a policy. Your results will be different. The Owner has requested an acceleration payment equal to half of the Eligible Proceeds, or \$97,500. This amount was calculated by subtracting the outstanding loan from the face amount of the Policy and taking half of that amount.

Accelerated Death Benefit would be calculated as follows: amount of Eligible Proceeds requested to accelerate, less actuarial discount for interest and reduced life expectancy and less the processing charge.

$\$97,500 - \$5,301 - \$150 = \$92,049$.

| | Before | After |
|--------------------------|-----------|-----------|
| Face Amount: | \$200,000 | \$100,000 |
| Cash Value: | \$8,000 | \$4,000 |
| Outstanding Policy Loan: | \$5,000 | \$2,500 |
| Annual Premium: | \$1,050 | \$525 |

COST

There is no additional premium charged to add this Rider to a policy. There will be a processing charge when an accelerated death benefit payment is made not to exceed \$150.

ACCELERATION

The acceleration can be processed if the Insured has a medical condition that is expected to result in death within 24 months. To make a claim, provide us with a statement signed by a physician that the Insured has a medical condition that is expected to result in death within 24 months. The physician may not be the Owner, the Insured, or a member of the Insured's family. We have the right to have the Insured examined at our expense by a physician we choose. This right will be exercised at places convenient to the Insured. The Rider outlines other conditions for acceleration.

LIMITS OF THE ACCELERATION OF DEATH BENEFIT RIDER

THE RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT DESIGNED TO ELIMINATE THE NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated death benefit payment. An accelerated death benefit payment may not be enough to cover your medical or other bills.

OTHER OPTIONS

Even though it is attached to the Policy, the Rider does not have to be exercised. The Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. Alternatively, if provided for by your Policy, you may elect to receive a loan, a partial withdrawal or to make a surrender.

TERMINATION OF ACCELERATED DEATH BENEFIT

The Rider will terminate at the earliest of:

1. When an Accelerated Death Benefit is paid;
2. When the Policy to which this Rider is attached terminates; and
3. The monthly anniversary on or following receipt by us at our Home Office or any other office designated by us of your written request to terminate this Rider. We may require the Policy for endorsement.

The Rider will not take effect if its attachment to the Policy could cause the Policy to be disqualified as life insurance under the Internal Revenue Code.



Important Notice Regarding Replacement of Insurance

Company Copy

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

- Metropolitan Life Insurance Company
- New England Life Insurance Company
- MetLife Investors Insurance Company

- General American Life Insurance Company
- MetLife Investors USA Insurance Company

For questions, contact your representative or call 1-800-METLIFE.

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER: _____
(Use additional sheets, as necessary.) (Name of Applicant)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? Yes No

IF YES, explain: _____

2. Are there penalties, set up charges or surrender charges for the new policy? Yes No

IF YES, explain, emphasizing any extra cost for early withdrawal: _____

3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction? Yes No

IF YES, explain: _____

4. Are there adverse tax consequences from the replacement under current tax law? Yes No

IF YES, explain: _____

5. a) Are interest earnings a consideration in this replacement? Yes No

b) **IF YES,** explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees, and other factors. _____

6. Are minimum amounts required to be on deposit before excess interest will be paid? Yes No

IF YES, explain: _____

7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:

- a) Are the interest rates quoted **BEFORE** or **AFTER** fees and mortality charges have been deducted?
- b) Interest rates are guaranteed for how long? _____
- c) The minimum interest rate to be paid is how much? _____
- d) If applicable, the rate you pay to borrow is and the limit on the amount that can be borrowed is _____
- e) The surrender charges are _____
- f) The death benefit is _____



Important Notice Regarding Replacement of Insurance

Company Copy

8. Are there other short or long term effects from the replacement that might be materially adverse Yes No

IF YES, explain: _____

Signatures

Signature of Agent or Broker

Date

▶ _____

Name of Agent or Broker (Print or Type)

Address

EXISTING INSURANCE WHICH MAY BE REPLACED:

| Full Name of Insurance Company Including Home Office Location | Policy or Contract Number * | Insured |
|---|-----------------------------|---------|
| | | |
| | | |
| | | |
| | | |

*or application or receipt number

CAUTION: THE INSURANCE COMMISSIONER SUGGESTS YOU CONSIDER THESE POINTS:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

COMPLETED COPY RECEIVED:

Applicant's Signature

Date

▶ _____

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

