

IMPORTANT INFORMATION FOR AGENTS

- ☑ Applications and forms applicable to the Value, Ideal, Premier and Facilities-Only LTCI policies are included. (State variations may apply.)
- ☑ Complete all relevant application pages. Tear out all **GOLD** pages and return them to MetLife ILTC at the appropriate address for your distribution channel. **BLUE** application pages stay with the applicant.
- ☑ *Is this applicant age 56 -74?*
All applicants between the ages 56 - 74 will require a phone health interview. Call is initiated by a Registered Nurse representing MetLife. The interview lasts approximately 20 - 30 minutes, depending on health history. To save time during the interview, please ask your client to have the following available:
 - Current medication bottles
 - Names of physicians
 - Dates of any surgeries/hospitalizationsPlease indicate under Part E: *Details and Additional Information*, the best time to reach your client.
- ☑ A minimum of 2 months premium must be taken if you are collecting any premium payment at time of application and client elects Automatic Checking Account Deduction (EFT) in Part D of the application.

For the Residents of the State of
New Jersey

LTC00453(0803)

Things You Should Know Before You Buy Long-Term Care Insurance

Long-Term Care Insurance

A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- You should **not** buy this policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare does **not** pay for most long-term care.

Medicaid

Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

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Information from:
 Applicant
 Agent

Long-Term Care Insurance PERSONAL WORKSHEET

People buy long-term care insurance for a variety of reasons. These reasons include to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. However, long-term care insurance can be expensive, and is not appropriate for everyone. In order to help you and the insurance company determine whether you should buy this policy, please complete this worksheet.

► **Premium**

The premium for the coverage you are considering will be: \$_____ per month, or \$_____ per year.

The company has a right to increase premiums in the future. The company has sold long-term care insurance since 1986, and has sold this policy since 2002. The company has not raised its rates for this policy.

Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?

► **Income**

Where will you get the money to pay each year's premiums? Income Savings Family members

What is your annual income? (check one) Under \$10,000 \$10,000 - \$19,999 \$20,000 - \$29,999
 \$30,000 - \$49,999 Over \$50,000

How do you expect your income to change over the next 10 years? (check one)

No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

► **Saving and Investments**

Not counting your home, what is the approximate value of all of your assets (savings and investments)? (check one)

Under \$20,000 \$20,000 - \$29,999 \$30,000 - \$49,999 Over \$50,000

How do you expect your assets to change over the next ten years?

Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider the other options for financing your long-term care.

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 Applicant
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Long-Term Care Insurance PERSONAL WORKSHEET (CONTINUED)

DISCLOSURE STATEMENT

Applicant (check one):

- The information provided on this worksheet accurately describes my financial situation. I choose not to complete this information.

Signed: **X** _____

Date: _____

Agent:

- I explained to the applicant the importance of completing this information.

Signed: **X** _____
(Agent)

Date: _____

Agent's Printed Name: _____

Applicant:

- My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.

Signed: **X** _____
(Applicant)

Date: _____

The company may contact you to verify your answers.



Application for Individual Long-Term Care Insurance

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A complete copy of this application consists of pages 1-7.

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MetLife

Information from:
 Applicant
 Agent

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PART **A** INSURABILITY QUESTIONS

▶ Please answer these questions ***BEFORE*** You begin filling out other parts of this Application.

1. Have You ever been specifically diagnosed or treated by any medical professional for any of the following conditions:
 - a. Yes No Alzheimer's disease, organic brain syndrome, dementia, frequent or persistent forgetfulness, mental retardation, or senility?
 - b. Yes No Parkinson's disease or syndrome, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease) or muscular dystrophy?
 - c. Yes No Stroke or any other type of cerebral vascular accident (CVA) or transient ischemic attack (TIA): (a) within the last 5 years; (b) with residual impairment; (c) with multiple events; or (d) in combination with diabetes, circulatory or heart disease, or tobacco use?
 - d. Yes No Immune Deficiency Disorder, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS related complex) or any AIDS related condition(s)?
 - e. Yes No Cancer with metastasis; or cancer treated in the past 24 months with chemotherapy, radiation, surgery or bone marrow transplant (except basal cell cancer, or early stage breast or prostate cancer)?
 - f. Yes No Cirrhosis of the liver?
 - g. Yes No Emphysema, chronic obstructive pulmonary disease or any chronic respiratory disease, in combination with smoking?
 - h. Yes No Congestive heart failure for which you are currently being treated (including treatment by medication)?
 - i. Yes No Diabetes with amputation or complications affecting the kidney?
 - j. Yes No Schizophrenia; or any other mental or nervous disorder for which You have been hospitalized in the past 2 years or have had multiple hospitalizations?
2. Yes No Have You had or have You ever been advised by a physician to have any organ transplant?
3. Yes No Do You currently use a walker, wheelchair or respirator?
4. Yes No Do You currently receive dialysis or oxygen treatment?
5. Yes No Are You currently residing in a nursing home or assisted living facility; or are You receiving home health care services or attending adult day care?
6. Yes No Do You need assistance or supervision in performing any of the following activities: moving in/out of chair or bed, bathing, dressing, eating, toileting, continence or walking?

If You answered "YES" to any part of PART A, questions 1-6, PLEASE DO NOT CONTINUE.
We regret that we cannot offer You long-term care insurance coverage.

If You answered "NO" to all of PART A, questions 1-6, please CONTINUE...

▶ **Agent**

Pages 1-10, the Authorization, and, if a replacement policy,
the Replacement Notice must be submitted to:

Metropolitan Life Insurance Company

Individual Long-Term Care

at the appropriate address for your distribution channel.

Payment Enclosed: \$_____





PART B PERSON WHO IS APPLYING FOR COVERAGE

Please print. Complete ALL information.

1. Mr./Mrs./Ms.: _____
circle one First Name Middle Initial
Last Name
2. Address: _____ Apt. # _____
3. City: _____
4. State: _____ Zip: _____
5. Home Phone: (____) _____
6. Work Phone: (____) _____
7. Gender: Male Female
8. Date of Birth: Month _____ Day _____ Year _____
9. Social Security #: - -
10. Marital Status: Single Married
(Please check "Single" if you are widowed or divorced.)

- AGENT: Complete this section.** Offered through:
 MLFS NEF GenAm MLR
 General Agent (other than GenAm) Other _____
11. Is Your Spouse applying for coverage? Yes No
12. If yes, Your Spouse's name: _____
Spouse's Social Security #: _____
 - -
13. Is any other member of Your household applying for coverage? Yes No
14. If yes, name: _____
Social Security #: - -
15. Your Mother's Maiden Name: _____

PART C COVERAGE YOU ARE APPLYING FOR

1. **Choose a (a) Plan, (b) Daily Benefit Amount (DBA), (c) Percentage of DBA paid for other Primary Services (Basic Services for Premier Plan), and (d) Rider if applicable:**
- | | | | |
|--|---|--|--|
| (a) <input type="checkbox"/> Value Plan | <input type="checkbox"/> Ideal Plan | <input type="checkbox"/> Premier Plan | <input type="checkbox"/> Facilities only Plan |
| (b) \$_____per day
(\$50 to \$400) | \$_____per day
(\$50 to \$400) (paid monthly) | \$_____per day
(\$50 to \$400) | \$_____per day
(\$50 to \$400) |
| (c) Home Care and Assisted Living Facility paid at:
<input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% | Home Care paid at:
<input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% | Basic Services paid at:
<input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% | (paid monthly) |
| (d) <input type="checkbox"/> Indemnity Rider | <input type="checkbox"/> Home Care Plus Rider | | |
2. **Total Lifetime Benefit:**
 2 yrs. 3 yrs. 4 yrs. 5 yrs. 7 yrs.
 Unlimited (available through age 79, not available with Premier)
3. **Elimination Period:**
 20 days 45 days 100 days
4. **Optional Nonforfeiture Coverage Rider:** Yes No
Check here to confirm:
 I have been offered the option to purchase a Nonforfeiture Coverage Rider.
 **INITIAL HERE IF YOU REJECT THIS OFFER:**
_____ I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with Nonforfeiture coverage, and I reject the Nonforfeiture Coverage Rider.
Please Note: If You select No, You will automatically receive the Contingent Benefits Upon Lapse Rider for no additional premium.
5. **Inflation Protection Riders:**
 5% Automatic Compound 5% Automatic Simple
 No Inflation Protection
Check here to confirm:
 I have been offered the option to purchase a 5% Compound Increase Inflation Protection Rider.
 **INITIAL HERE IF YOU REJECT THIS OFFER:**
_____ I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this policy with and without the Automatic 5% Compound Increase Inflation Protection Rider. Specifically, I have reviewed options for Compound and Simple increases, and I reject the 5% Compound Increase Inflation Protection Rider.
6. **Optional Riders:** (Not all riders are available with all Plans and Options.)
 Yes No Restoration of Benefits Rider
 Yes No Shared Care Rider
 Yes No Future Purchase Rider
 Yes No Other _____
7. This is a request for:
 Initial coverage Increase in coverage

MAIL this page to MetLife
ENCLOSE CHECK and/or
VOIDED CHECK

Information from:
 Applicant
 Agent

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PART **D** HOW YOU WANT TO PAY PREMIUMS

▶ **Choose a Premium Payment Option/Rider (Not available for coverage increases):**

1. **Premium Payment Options:** Standard Double Pay First Year Reduced Pay at 65
 10 year Premium Payment Rider Paid up Premiums Rider

▶ **Choose one payment method from 2-5.**

Please note that paying insurance premiums more often than annually will cost more than paying them once a year.

2. **Bill me by mail:**

- Quarterly
 Semi-Annually
 Annually

3. **Third-party payer (if applicable):**

Please mail premium bill

- Quarterly
 Semi-Annually
 Annually to:

Full Name: _____

Address: _____ Apt. # _____

City: _____

State: _____ Zip: _____

Telephone: (_____) _____

4. **Automatic Checking Account Deduction (Monthly):**

Your monthly premium will be deducted automatically from the bank or credit union checking account You request.



You must enclose a voided blank check for the account You wish to use.

If using a credit union account, provide credit union phone #: (_____) _____

I authorize: (1) MetLife to initiate monthly deductions from my checking account, by electronic or other means, as payment for the coverage level selected; and (2) the financial institution on which my enclosed sample check (marked VOID) is drawn to: (a) accept the deductions initiated by MetLife; and (b) give MetLife my most recent address upon MetLife's request. Deductions will continue until MetLife has had a reasonable opportunity to act upon my written request to end this service.

I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.



Signature of Account Holder for
Monthly Automatic Deductions

Date

5. **Protection Against Unintended Lapse**

Would You like to name a person in addition to yourself to receive notice if Your coverage is about to lapse due to lack of premium payment? Note: This person will NOT be responsible for payment of premiums.



Yes. If yes, please provide all information requested.

Full Name: _____ Relationship: _____

Address: _____ Apt. # _____ Telephone: (_____) _____

City: _____ State: _____ Zip: _____

Protection Against Unintended Lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.

No. SIGN HERE IF YOU REJECT THIS OFFER:



Signature of Proposed Insured

Date

PART E HEALTH INFORMATION

Primary Physician who has most of Your medical records:

Name: _____ Telephone: (_____) _____
Address: _____ City: _____
State: _____ Zip: _____ Date last seen: _____

Physician Specialist You see on a regular basis (if more than one, please list on page 6):

Name: _____ Telephone: (_____) _____
Address: _____ City: _____
State: _____ Zip: _____ Date last seen: _____

Reason: _____

► For any “Yes” answers, circle specific condition(s) that apply and give DETAILS on page 6:

1. Have You ever been specifically diagnosed or treated by any medical professional for any of the following conditions:
- a. **Yes** **No** Cancer (except basal cell cancer)?
 - b. **Yes** **No** Heart disease, congestive heart failure, angina, heart attack, heart surgery, angioplasty or hypertension?
 - c. **Yes** **No** Stroke or any other type of cerebral vascular accident (CVA); transient ischemic attack (TIA)?
 - d. **Yes** **No** Chronic lung, liver or kidney disease?
 - e. **Yes** **No** Diabetes – insulin or non-insulin dependent?
 - f. **Yes** **No** Chronic neurological disease (e.g., brain disorder or seizure disorder, or conditions of the spine or peripheral nerves) or any psychiatric disorder (e.g., bipolar disorder, depression)?
 - g. **Yes** **No** Osteoarthritis, rheumatoid arthritis, immune system disorders or any connective tissue disorders (e.g., lupus erythematosus, scleroderma, etc.)?
 - h. **Yes** **No** Amputation, osteoporosis, joint replacement or fractured hip?
 - i. **Yes** **No** More than one fractured bone or any falls, in the last 2 years?
 - j. **Yes** **No** Paralysis, weakness or numbness of extremities, tremors, imbalance, gait disturbance or dizziness?
 - k. **Yes** **No** Memory loss?
2. Have You ever:
- a. **Yes** **No** been treated with steroids (e.g., prednisone) or other immunosuppressants, methotrexate or gold on an ongoing or intermittent basis?
 - b. **Yes** **No** been eligible to receive payment for Long-Term Care services under any Long-Term Care Insurance Plan?
 - c. **Yes** **No** applied for or been declined coverage for Long-Term Care insurance?
3. **Yes** **No** Have You ever resided in or been advised to enter a nursing home, assisted living facility or retirement community; or have You ever received home health care services or attended adult day care?
4. **Yes** **No** Do You currently use any medical equipment (e.g., cane, brace, crutches, hospital bed or stair lift)?
5. **Yes** **No** Do You require assistance in activities such as shopping, managing finances, meal preparation, transportation or taking Your medications?
6. **Yes** **No** In the last 2 years, have You been hospitalized?
7. **Yes** **No** Have You had any past surgeries, or do You plan to have surgery; or have You been advised to seek medical attention for any symptoms, testing, surgery or treatment?

PART E HEALTH INFORMATION (CONTINUED)

8. Yes No Have You taken any prescription medications during the past 12 months?

If You answered “YES” to question 8, please provide details about those medications here. Please use additional space provided on page 6, if necessary.

Medication	Dosage	Frequency	Reason Prescribed	Name and Address of Physician
				Name: _____ Address: _____
				Name: _____ Address: _____
				Name: _____ Address: _____
				Name: _____ Address: _____

9. Yes No Do You currently use tobacco products?

If “Yes,” frequency/amount _____ Date of last use: _____

10. Yes No Do You currently use alcoholic beverages?

If “Yes,” frequency/amount _____ Date of last use: _____

11. Yes No Have You ever been treated, hospitalized or counseled for the use of alcohol or controlled substances?

12. Height (inches): _____ Weight (pounds): _____

13. Yes No Are you currently receiving any disability income, workmen’s compensation, social security disability income, or any federal or state disability?

14. Yes No Have You ever had an application for Life, Health or Long Term Care Insurance declined, postponed or rated?

15. Do You:

a. Yes No exercise? If yes, please describe _____

b. Yes No drive a motor vehicle? If yes, how many miles per week? _____

c. Yes No work outside the home? If yes, please describe _____

d. Yes No do volunteer work? If yes, please describe _____

e. Yes No have hobbies? If yes, please describe _____



PART F REPLACEMENT QUESTIONS

You MUST answer all questions or We will not be able to process this application.

Regulations of certain states require that We ask the following questions if You are applying for insurance.

1. Yes No Do You have another long-term care insurance policy or certificate in force (including a health care service contract or a health maintenance organization contract)?
If "Yes," the types and amounts of coverage? _____

2. Yes No Did You have another long-term care insurance policy or certificate in force during the last twelve (12) months?
If "Yes," with which insurance company? _____
If that policy or certificate lapsed, when did it lapse? _____

3. Yes No Are You covered under Medicaid? ("Medicaid" is different from "Medicare.")

4. Yes No Do You intend to replace any of Your long-term care, medical or health insurance coverages with this policy?

If "Yes," complete information:

Policy #: _____

Insurance Company Name: _____

Insurance Company Address: _____

PART G AGREEMENT AND ACKNOWLEDGEMENT

▶ **Required Information.** Please check to indicate that You have received the following items:

- | | |
|---|--|
| <input type="checkbox"/> Outline of Coverage for the policy applied for, which includes a graphic comparison of a policy with and without the 5% Automatic Compound Inflation Protection Rider. | <input type="checkbox"/> Shopper's Guide to Long-Term Care |
| | <input type="checkbox"/> If this is a replacement policy, Replacement Notice |
| | <input type="checkbox"/> MetLife's Consumer Privacy Notice |

I represent that all information supplied in this Application is true and complete. I understand that, if this is an application for a new policy, then except as stated in the Conditional Premium Receipt, MetLife will have no liability until a policy is personally delivered to me and the full first premium is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change then the coverage change will take effect on the effective date of the change.

I understand that : (1) the policy, if no Conditional Premium Receipt has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is delivered to me; or (2) the date on which any coverage change is scheduled to go into effect.

Wherever my Initials appear in this application, it shall have the same force and effect as if I had signed my name in full on the date shown below.

I have read the above answers and statements on this Application. I declare that they are true and complete.

Caution: *If Your answers or statements on this application are incorrect or untrue, MetLife has the right to deny benefits or rescind Your policy.*

Fraud Warning: Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.



Signature of Proposed Insured

Date

Print Name of Proposed Insured



Signature of Witness

Print Name of Witness

Signed at City, State

MAIL this page to MetLife
MLFS: Manager signature
required

Information from:
 Applicant
 Agent

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PART **H** AGENT'S REPORT

Please provide complete details to ensure against delays in processing this application.

- Yes No Did you personally interview the Proposed Insured face to face and witness his or her signature?
If no, give details: _____
- Yes No Did you observe any physical or mental impairments with regard to the Proposed Insured's walking or talking, or any form of tremor? If yes, please describe: _____

- Please list other health insurance policies sold by you to the Proposed Insured that are still in-force: _____

- List health insurance policies sold by you in the last five years to the Proposed Insured that are no longer in-force: _____

- Yes No Is this a replacement policy? (If yes, provide Replacement Notice)
- Modal Premium Annualized Premium Production Credit/Commission
\$ _____ \$ _____ \$ _____
- For split commission cases, provide the information requested below, indicating the percentage of commission applicable to each:

	Print Name	Signature	Office ID#	Producer #	SS#	Percent
1 st Rep.						
2 nd Rep.						
3 rd Rep.						

I certify that each question was asked of the Proposed Insured and answered as recorded. All answers on this application are correct to the best of my knowledge and belief. I certify that any required written disclosure statement was given to the Proposed Insured no later than the date this application was signed.

X _____
Signature of Licensed & Appointed Agent

_____ Name of Licensed & Appointed Agent (Please Print)

Office ID# _____ Producer # _____ SS# _____

Street Address _____ Apt. # _____
Phone/Fax _____

City _____ State _____ Zip _____ e-mail address _____

MLFS ONLY: To Be Completed By Agency Manager or District Manager

- Reviews Yes No Have you personally reviewed this application?
 Yes No Have you personally reviewed the Personal Worksheet?

If the policy does not appear to be suitable, where is the source of premium? _____

IMPORTANT: This application will NOT be processed without this signature.

- Signature and Title **X** _____ Date _____



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Applicant

Information from:
 Applicant
 Agent

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PART I CONDITIONAL PREMIUM RECEIPT

Received from _____ \$ _____ on _____
Name of Proposed Insured (Please print) Amount Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS CONDITIONAL PREMIUM RECEIPT UNTIL METLIFE APPROVES THE APPLICATION.

It is understood and agreed that payment of the premium shown above under this Conditional Premium Receipt is made and accepted subject to the following conditions:

1. If, after We (Metropolitan Life Insurance Company ("MetLife")) receive: (a) the Initial Application Requirements, as defined below; and (b) evidence of insurability acceptable to Us, We determine that as of the date of the application, You are insurable based upon Our underwriting criteria and standards for the insurance coverage applied for, **the policy will take effect on the date the application was signed**. Any changes in Your health after the date of this Receipt will not affect Our underwriting decision.
2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy.

For purposes of this Receipt, the Initial Application Requirements are:

1. Completion of the application, in which You have answered "No" to all Questions in Part A of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by Us.
3. Receipt by Us of any Attending Physician Statement(s), medical records and any other medical documents that We may require.
4. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all Questions in Part A of the application are relied upon to accept payment and issue this Receipt. If any of these answers are incomplete or incorrect, or MetLife is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this Receipt will be null and void from the beginning.

If We determine that as of the date of the application You are not eligible for the insurance coverage applied for, coverage under this Receipt will not become effective. There will be no Coverage under the Conditional Premium Receipt and the amount paid will be returned to You.

Limitations on Authority: No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Conditional Premium Receipt. No agent, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of Our requirements.

Company Copy

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Information from:
 Applicant
 Agent

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PART I **CONDITIONAL PREMIUM RECEIPT (CONTINUED)**

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part A of the application. I represent that the answers to all those Questions are true and complete. I understand and agree that if the answers to any of the Questions in Part A of the application are not true and complete, the amount tendered will be returned and this Conditional Premium Receipt will be null and void from the beginning. I understand and agree to all of the terms of this Conditional Premium Receipt. I have received a copy of this Conditional Premium Receipt.

✕ _____
Signature of Proposed Insured

_____ Date

No agent or financial services representative is authorized to accept any payment with the application if You answered "Yes" (or left blank) to any of the Questions in Part A of Your application.

Receipt of \$ _____ is acknowledged from _____
in connection with the application for long-term care insurance on this date _____

By: _____ Metropolitan Life Insurance Company
Countersignature

Gwenn L. Carr
Gwenn L. Carr
Vice-President and Secretary

Title: _____ District/Branch: _____

MetLife makes no representations as to the tax consequences of premium paid under this Receipt or the Benefits You receive under this Receipt. Consult Your own legal or tax advisor.

**ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

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Applicant

Information from:
 Applicant
 Agent

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PART I **CONDITIONAL PREMIUM RECEIPT**

Received from _____ \$ _____ on _____
Name of Proposed Insured (Please print) Amount Date

THERE IS NO COVERAGE IN EFFECT UNDER THIS CONDITIONAL PREMIUM RECEIPT UNTIL METLIFE APPROVES THE APPLICATION.

It is understood and agreed that payment of the premium shown above under this Conditional Premium Receipt is made and accepted subject to the following conditions:

1. If, after We (Metropolitan Life Insurance Company ("MetLife")) receive: (a) the Initial Application Requirements, as defined below; and (b) evidence of insurability acceptable to Us, We determine that as of the date of the application, You are insurable based upon Our underwriting criteria and standards for the insurance coverage applied for, **the policy will take effect on the date the application was signed.** Any changes in Your health after the date of this Receipt will not affect Our underwriting decision.
2. If We issue a policy to You, any unpaid balance of the first full premium due, in accordance with the premium payment mode You have selected, must be paid upon delivery of the policy.

For purposes of this Receipt, the Initial Application Requirements are:

1. Completion of the application, in which You have answered "No" to all Questions in Part A of the application.
2. Completion of an acceptable underwriting assessment, nurse interview, physical examination and assessment, if required by Us.
3. Receipt by Us of any Attending Physician Statement(s), medical records and any other medical documents that We may require.
4. The full amount of any check, draft or money order paid under this Receipt must be honored on its first presentation for payment.

CAUTION: Your answers to all Questions in Part A of the application are relied upon to accept payment and issue this Receipt. If any of these answers are incomplete or incorrect, or MetLife is unable to approve the application within 75 days from the date of the application, the amount paid will be returned and this Receipt will be null and void from the beginning.

If We determine that as of the date of the application You are not eligible for the insurance coverage applied for, coverage under this Receipt will not become effective. There will be no Coverage under the Conditional Premium Receipt and the amount paid will be returned to You.

Limitations on Authority: No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Conditional Premium Receipt. No agent, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of Our requirements.

Proposed Insured's Copy

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Applicant

Information from:
 Applicant
 Agent

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PART I **CONDITIONAL PREMIUM RECEIPT (CONTINUED)**

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part A of the application. I represent that the answers to all those Questions are true and complete. I understand and agree that if the answers to any of the Questions in Part A of the application are not true and complete, the amount tendered will be returned and this Conditional Premium Receipt will be null and void from the beginning. I understand and agree to all of the terms of this Conditional Premium Receipt. I have received a copy of this Conditional Premium Receipt.

✕ _____
Signature of Proposed Insured

_____ Date

No agent or financial services representative is authorized to accept any payment with the application if You answered "Yes" (or left blank) to any of the Questions in Part A of Your application.

Receipt of \$ _____ is acknowledged from _____
in connection with the application for long-term care insurance on this date _____

By: _____ Metropolitan Life Insurance Company
Countersignature

Gwenn L. Carr
Gwenn L. Carr
Vice-President and Secretary

Title: _____ District/Branch: _____

MetLife makes no representations as to the tax consequences of premium paid under this Receipt or the Benefits You receive under this Receipt. Consult Your own legal or tax advisor.

**ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

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 Applicant
 Agent

CONSUMER PRIVACY NOTICE

Metropolitan Life Insurance Company

If you submit a request for insurance (application or enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company (MetLife).

Please read this Privacy Notice carefully. It describes how we learn about you and how we treat the information we collect about you. (If anyone else is to be insured under the coverage you request, what we say here also applies to information about them.)

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 asked for. 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 prevent money laundering and terrorism.

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

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 in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, health care providers and others. The Authorization that you sign when you applied for insurance permits these sources to tell us about you. So we may, for instance, 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

How We Protect What We Know: 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 take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. 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 and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Tell a group customer about its members' claims or cooperating in a group customer's audit of our service.

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

PLEASE KEEP THIS NOTICE FOR YOUR RECORDS

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Information from:
 Applicant
 Agent

CONSUMER PRIVACY NOTICE (CONTINUED)

- 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
- 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

Generally, we will disclose only the information we consider reasonably necessary to disclose.

How We Use and Disclose What We Know About You to Offer You Other Products and Services:

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") PROTECTS YOUR INFORMATION IF YOU REQUEST OR PURCHASE LONG-TERM CARE INSURANCE FROM US. IN ADDITION TO THE LIMITATIONS DESCRIBED IN THIS SECTION "**HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU TO OFFER YOU OTHER PRODUCTS AND SERVICES,**" HIPAA FURTHER LIMITS OUR ABILITY TO USE AND DISCLOSE THE INFORMATION THAT WE OBTAIN AS A RESULT OF YOUR REQUEST OR PURCHASE OF LONG TERM CARE INSURANCE. INFORMATION ABOUT YOUR RIGHTS UNDER HIPAA WILL BE PROVIDED TO YOU WITH ANY LONG TERM CARE COVERAGE ISSUED TO YOU. FOR MORE INFORMATION SEE THE LAST PARAGRAPH OF THIS NOTICE.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information):

- to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise we don't have to let you prevent these disclosures. 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.
- to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you.
- to other financial services companies, if we have joint marketing agreements with them so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company.

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.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only 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 when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: This is a general description of MetLife's information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. For example, individuals who request or purchase long term care insurance coverage from us have rights under HIPAA. For additional information about your rights under HIPAA, or, for other information about privacy please contact us at our website, www.metlife.com, or write to MetLife, P.O. Box 937, Westport, Connecticut 06991-0937.

MetLife[®]

Information from:
 Applicant
 Agent

Complete this page for REPLACEMENT POLICIES only.

LEAVE Give this copy to applicant

If question #4 in Part F is answered YES, complete this Notice and leave a copy with the Applicant.

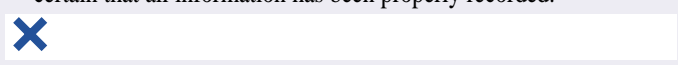
NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE (LTC) INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to Your application, You intend to lapse or otherwise terminate existing accident and sickness insurance or long-term care insurance coverage and replace it with an individual long-term care insurance policy issued by Metropolitan Life Insurance Company. Your new policy provides thirty (30) days within which You may decide, without cost, whether You desire to keep the policy. For Your own information and protection, You should be aware of and seriously consider certain factors which may affect the insurance protection available to You under the new policy.

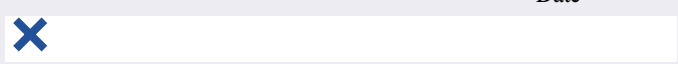
You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage You now have, and terminate Your present policy only if, after due consideration, You find that purchase of this long-term care insurance coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT: *(Use additional sheets as necessary.)* I have reviewed Your current medical, health, and LTC insurance coverage. I believe the replacement of insurance involved in this transaction materially improves Your position. My conclusion has taken into account the following considerations, which I call to Your attention:

1. The policy has no exclusion for pre-existing conditions. This means that health conditions which You may presently have are fully and immediately covered under the new policy, if such policy is issued.
2. In many states, state law provides that Your replacement policy may not contain new pre-existing conditions or probationary periods. The policy You are applying for has no such pre-existing conditions or probationary periods.
3. Since You are planning to replace medical, health, or LTC insurance coverage, You may wish to secure the advice of Your present insurer or its agent regarding the proposed replacement of Your present coverage. This is not only Your right, but it is also in Your best interest to make sure You understand all the relevant factors involved in replacing Your present coverage.
4. If, after You have thought about it, You still wish to terminate Your present coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning Your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund Your premium as though Your policy had never been in force. After the application has been completed and before You sign it, reread it carefully to be certain that all information has been properly recorded.


 Signature of Sales Representative, Agent or Broker

Print Name and Address of Sales Representative, Agent or Broker
 The above "Notice to Applicant" was delivered to me on: _____ Date


 Signature of Proposed Insured

MAIL Send this copy with application

If question #4 in Part F is answered YES, complete this Notice and leave a copy with the Applicant.


NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE (LTC) INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to Your application, You intend to lapse or otherwise terminate existing accident and sickness insurance or long-term care insurance coverage and replace it with an individual long-term care insurance policy issued by Metropolitan Life Insurance Company. Your new policy provides thirty (30) days within which You may decide, without cost, whether You desire to keep the policy. For Your own information and protection, You should be aware of and seriously consider certain factors which may affect the insurance protection available to You under the new policy.

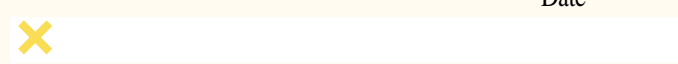
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 Signature of Sales Representative, Agent or Broker

Print Name and Address of Sales Representative, Agent or Broker
 The above "Notice to Applicant" was delivered to me on: _____ Date


 Signature of Proposed Insured

AGENT DETACH HERE