Important Notice to Agents/Producers regarding the Personal Worksheet

Please be advised:

- Effective October1, 2009, this Personal Worksheet replaces the Personal Worksheet found inside this application.
- Applications submitted on or after this date must use the new Personal Worksheet.
- Delays in processing your application will occur if you submit an application with the old Personal Worksheet after this date.
- If your client chooses not to complete the Personal Worksheet, our standard procedure will apply and your client must complete the Authorization to Proceed Processing Application Form.

_______________ **APPLICANT A** **APPLICANT B** _______________

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they receive. Others don't want their family to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.
By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Number: LTC2007 Policy Series

The premium for the coverage you are considering will be:

Premium Rate: The following premium rate is applicable to you and will be in effect until a request for an increase is made and filed with your state Insurance Department (choose one for each applicant):

APPLICANT A ❑ $_______ per month, or ❑ $ ________per quarter, or ❑ $ ________semi-annually, or ❑ $ _______annually

APPLICANT B ❑ $_______ per month, or ❑ $ ________per quarter, or ❑ $ ________semi-annually, or ❑ $ _______annually

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History: The company has sold long-term care insurance since 1986 and has sold this policy series since 2007. In 2009, MetLife applied a new premium rate schedule to individual long-term care insurance policy forms currently for sale in this and other states, where approved. Please note: The new premium rate schedules do not apply to any coverage that was in place prior to implementation of the new premium rates in that state. Your Agent/Producer can provide you with up-to-date information concerning the status of the approval of these new premium rate schedules in your particular state.

With respect to premium rates for existing policyholders, MetLife has raised rates on the two policy series noted below.

Policy Type	Individual Policy Series	Years Available	Years of Increase	Percentage of Increase
Individual LTC	1LTC-97, 2LTC-97	1997 - 2001	2009	0-18%
Individual LTC	LTC-VAL, LTC-IDEAL, LTC-PREM, LTC-FAC	2002 - 2006	2009	0-18%

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium? (check one)
APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay
APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

---

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?
APPLICANT A ❑ Yes ❑ No
APPLICANT B ❑ Yes ❑ No

What is your annual income? (check one)
APPLICANT A ❑ Under $10,000 ❑ $10,000 - $19,999 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000
APPLICANT B ❑ Under $10,000 ❑ $10,000 - $19,999 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

How do you expect your income to change over the next ten years? (check one)
APPLICANT A ❑ No change ❑ Increase ❑ Decrease
APPLICANT B ❑ 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.

Will you buy inflation protection? (check one)
APPLICANT A ❑ Yes ❑ No
APPLICANT B ❑ Yes ❑ No

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET – *continued*

QUESTIONS RELATED TO YOUR INCOME (Continued)

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay

APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

The national average annual cost of Nursing Home care in 2007 was $68,985, but this figure varies across the country. In ten years the national average annual cost would be about $112,369 if costs increase 5% annually.

What elimination period are you considering?

APPLICANT A 100 Number of days $ __________ Approximate cost for that period of care

APPLICANT B 100 Number of days $ __________ Approximate cost for that period of care

---

How are you planning to pay for your care during the elimination period? (check one)

APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay

APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

---

QUESTIONS RELATED TO YOUR SAVINGS/INVESTMENTS

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

APPLICANT A ❑ Under $20,000 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

APPLICANT B ❑ Under $20,000 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

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

APPLICANT A ❑ Stay about the same ❑ Increase ❑ Decrease

APPLICANT B ❑ 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.

DISCLOSURE STATEMENT

APPLICANT A		APPLICANT B
❑ ❑	**(Each applicant MUST check one):** The answers to the questions above describe my financial situation **OR** I choose not to complete this information.	❑ ❑
❑	**(This box must be checked.)** I acknowledge that the carrier and/or its Agent/Producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** X ______________________ Signature of **APPLICANT A** Date X ______________________ Signature of **APPLICANT B** Date	❑
❑	**AGENT/PRODUCER** I explained to the applicant the importance of completing this information. X ______________________ Print Name of Licensed & Appointed Agent/Producer X ______________________ Signature of Licensed & Appointed Agent/Producer Date **In order for us to process your application, please return this signed statement to MetLife, along with your application.**	❑
❑	My Agent/Producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application. X ______________________ Signature of **APPLICANT A** Date X ______________________ Signature of **APPLICANT B** Date The company may contact you to verify your answers.	❑

MetLife®

Metropolitan Life Insurance Company
New York, NY

LTC05098 (0809) L-INFC-IND-PW07(0809)

For use in the state of:

Connecticut

MetLife®

Individual Long-Term Care Insurance (LTCI) Application Packet

Table of Contents

MetLife LTC LifeStage Advantage℠

Metropolitan Life Insurance Company ("MetLife"), New York, NY

IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

Complete this application for individual applicants only.
Multi-Life program applicants must use the Multi-Life application.
Complete required forms in Client Packet and leave with applicant.

All applicants between the ages of 56 - 69 will require a phone health interview. The call is initiated by a 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, addresses and phone numbers of physicians
- Dates of any surgeries or hospitalizations

All applicants between 70 - 84, inclusive, will require a face-to-face interview and assessment at their place of residence.

Medical records from the primary physician are required on all applicants age 61 and over.

Additionally, underwriters may order any underwriting requirement, regardless of age, to clarify the health history.

If you are collecting premium payment at time of application:

- If client is age 65 or over, only 1 month premium payment may be collected.
- If client is under age 65, you must collect full modal premium.

APPLICATION PACKET SUBMISSION CHECKLIST

To avoid a delay in processing, confirm the following sections have been completed:

❑ Name of Applicants **A** and **B** are at the top of **each** page.

❑ All Health Information is complete (pages 3-6).

❑ For Automatic Checking Account Deduction of premium, include a voided check and complete and sign Part F, Question 2 (page 7).

❑ The Medical Authorization is signed by the applicant(s) (pages 10-11).

❑ The Personal Worksheet is completed (pages 16-17).
If the applicant chooses not to complete the Personal Worksheet, please complete the Authorization to Proceed Processing Application Form (page 18).

❑ Correct distribution channel is selected and all information is completed accurately in Agent/Producer's Report (pages 20 -21).

❑ All signatures are complete.

Submit the entire completed application to MetLife at:

MetLife Long-Term Care
P.O. Box 64911
St. Paul, MN 55164-0911

Agent/Producer Distribution Channel: ❑ **MetLife** ❑ **NEF** ❑ **MLR** ❑ **General Agent/Producer** ❑ **Other** ____________(Firm Name)

PART A PERSON(S) APPLYING FOR COVERAGE (Each applicant must complete ALL information below.)

APPLICANT A

1. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. (check one)
2. First Name __________________________ Middle Initial ___
   Last Name ____
3. Address ____
   City _____________________ State_______ Zip _________
4. Preferred Contact Phone Number ( ) ______________________
   Additional Phone Number ( ) ____________________________
   Best time to call ❑ Morning ❑ Afternoon ❑ Evening
5. E-mail address _______________________________________
6. Gender ❑ Male ❑ Female
7. Date of Birth ____________________________(mm/dd/yyyy)
   Place of Birth __________________________ (State & Country)
8. Height __________________ Weight ____________________
9. Social Security Number _________________________________
10. Marital Status ❑ Single/Widowed/Divorced ❑ Married ❑ Domestic Partner*
11. Is your Spouse/Domestic Partner* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife? ❑ **YES** ❑ **NO**
    IF YES please identify and provide requested information.
    ❑ Spouse/Domestic Partner* ❑ Household Member
    Name ____
    Social Security Number _________________________________
12. This is a request for ❑ Initial Coverage ❑ Change in Coverage ❑ Re-apply ❑ Life/DI GPO Rider

APPLICANT B

Is **APPLICANT A** your
❑ Spouse/Domestic Partner* ❑ Household Member

1. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. (check one)
2. First Name __________________________ Middle Initial ___
   Last Name ____
3. Address ____
   City _____________________ State_______ Zip _________
4. Preferred Contact Phone Number ( ) ______________________
   Additional Phone Number ( ) ____________________________
   Best time to call ❑ Morning ❑ Afternoon ❑ Evening
5. E-mail address _______________________________________
6. Gender ❑ Male ❑ Female
7. Date of Birth ____________________________(mm/dd/yyyy)
   Place of Birth __________________________ (State & Country)
8. Height __________________ Weight ____________________
9. Social Security Number _________________________________
10. Marital Status ❑ Single/Widowed/Divorced ❑ Married ❑ Domestic Partner*
11. Is your Spouse/Domestic Partner* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife? ❑ **YES** ❑ **NO**
    IF YES please identify and provide requested information.
    ❑ Spouse/Domestic Partner* ❑ Household Member
    Name ____
    Social Security Number _________________________________
12. This is a request for ❑ Initial Coverage ❑ Change in Coverage ❑ Re-apply ❑ Life/DI GPO Rider

* "Domestic Partner" means each of two people: who have registered or filed as domestic partners or members of a civil union with a government agency or office where such registration is available; or who meet the following requirements: each person is 18 years of age or older; neither person is married; they share the same residence; they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and they have an exclusive mutual commitment to share the responsibility to each other's welfare and financial obligations and such commitment is expected to last indefinitely.

APPLICANT A ______ ______ APPLICANT B

PART B COVERAGE SELECTIONS

Select either Simple Advantage OR Custom Advantage

Simple Advantage (Only available to applicants age 61 and under.)

STEP 1 – Select the Maximum Amount of Initial Coverage you want: (Select one box)
This plan includes Guaranteed Purchase Option Rider.

APPLICANT A

TOTAL BENEFIT AMOUNT

MONTHLY BENEFIT AMOUNT	$75K	$100K	$200K	$300K	$400K	$500K
$3K	❑	❑	❑	❑	❑	–
$6K	–	–	❑	❑	❑	❑

APPLICANT B

TOTAL BENEFIT AMOUNT

MONTHLY BENEFIT AMOUNT	$75K	$100K	$200K	$300K	$400K	$500K
$3K	❑	❑	❑	❑	❑	–
$6K	–	–	❑	❑	❑	❑

STEP 2 – Decide whether you want any of the 2 optional benefit riders:

APPLICANT A
- ❑ Shared Care Rider*
- ❑ Nonforfeiture Coverage Rider

APPLICANT B
- Shared Care Rider* ❑
- Nonforfeiture Coverage Rider ❑

*Available to Spouses or Domestic Partners who are applying for identical coverage.

OR

Custom Advantage

STEP 1 – Select the Maximum Amount of Coverage you want: (Select one box)

TOTAL BENEFIT AMOUNT

MONTHLY BENEFIT AMOUNT	$75K	$100K	$200K	$300K	$400K	$500K	$1MM
$3K	❑	❑	❑	❑	❑	–	–
$6K	–	–	❑	❑	❑	❑	–
$9K	–	–	–	❑	❑	❑	❑
$12K	–	–	–	❑	❑	❑	❑
$15K	–	–	–	–	❑	❑	❑

TOTAL BENEFIT AMOUNT

MONTHLY BENEFIT AMOUNT	$75K	$100K	$200K	$300K	$400K	$500K	$1MM
$3K	❑	❑	❑	❑	❑	–	–
$6K	–	–	❑	❑	❑	❑	–
$9K	–	–	–	❑	❑	❑	❑
$12K	–	–	–	❑	❑	❑	❑
$15K	–	–	–	–	❑	❑	❑

STEP 2– Decide whether you want any of the 2 optional benefit riders:

APPLICANT A
- ❑ Shared Care Rider*
- ❑ Nonforfeiture Coverage Rider

APPLICANT B
- Shared Care Rider* ❑
- Nonforfeiture Coverage Rider ❑

*Available to Spouses or Domestic Partners who are applying for identical coverage.

STEP 3 – Select a Benefit Increase option: (Select one box)

APPLICANT A
- ❑ Future Purchase Rider
- ❑ 3% Automatic Compound Inflation Protection Rider
- ❑ 5% Automatic Compound Inflation Protection Rider
- ❑ I do not choose a Benefit Increase option.

APPLICANT B
- Future Purchase Rider ❑
- 3% Automatic Compound Inflation Protection Rider ❑
- 5% Automatic Compound Inflation Protection Rider ❑
- I do not choose a Benefit Increase option. ❑

______________ APPLICANT A APPLICANT B ______________

PART C INSURABILITY QUESTIONS (Please answer these questions BEFORE you continue with this application.)

APPLICANT A YES	APPLICANT A NO	To the best of your knowledge and belief:	APPLICANT B YES	APPLICANT B NO
❑	❑	1. Have you **ever** had, do you currently have, have you been medically diagnosed as having or have you been treated for: Stroke/Multiple Transient Ischemic Attacks (TIA's) **within the past 5 years**, multiple stroke/TIA, stroke with residual impairment; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; amyotrophic lateral sclerosis (ALS); or Huntington's chorea?	❑	❑
❑	❑	2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions?	❑	❑
❑	❑	3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	❑	❑
❑	❑	4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	❑	❑
❑	❑	5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; adult day care; any other type of long-term care facility; or home health care services?	❑	❑

If you answered YES to any of PART C, questions 1-5, PLEASE DO NOT CONTINUE. We regret that we cannot offer you Long-Term Care Insurance coverage. If you answered "NO" to all of PART C, questions 1-5, please CONTINUE.

PART D HEALTH QUESTIONS (Provide additional information in the DETAILS section on page 6.)

Primary Care Physician (with most of your records)

APPLICANT A

Physician ______________________________

Address ______________________________

City____________________ State ____ Zip______

Phone Number (___)__________ Date Last Seen ________

APPLICANT B

Physician ______________________________

Address ______________________________

City____________________ State____ Zip______

Phone Number (___)__________ Date Last Seen ________

All Physician Specialists (excluding podiatrists, dentists) seen in the past 5 years

Physician ______________________________

Address ______________________________

City____________________ State ____ Zip______

Phone Number (___)__________ Date Last Seen ________

Physician ______________________________

Address ______________________________

City____________________ State ____ Zip______

Phone Number (___)__________ Date Last Seen ________

Physician ______________________________

Address ______________________________

City____________________ State ____ Zip______

Phone Number (___)__________ Date Last Seen ________

Physician ______________________________

Address ______________________________

City____________________ State ____ Zip______

Phone Number (___)__________ Date Last Seen ________

PART D HEALTH QUESTIONS – *continued* (Provide additional information in the DETAILS section on page 6.)

APPLICANT A YES	APPLICANT A NO	**Underwriting requirements:** Applicants ages 56-69, inclusive, will have a phone health interview. Applicants ages 70-84, inclusive, will require a face-to-face interview in their place of residence. Additionally, we may conduct a health interview regardless of age, to clarify health status.	APPLICANT B YES	APPLICANT B NO
❑	❑	**To the best of your knowledge and belief:** 1. Have you **ever** had, or has a licensed member of the medical profession diagnosed you with or treated you for any of the following conditions? **If YES** check all applicable condition(s) for **each** applicant (**A** and **B**).	❑	❑

A		B	A		B
❑	Cancer (excluding basal cell of skin)	❑	❑	Arthritis	❑
❑	Heart disease/condition(s)	❑	❑	Connective tissue disorder	❑
❑	Atrial fibrillation	❑	❑	Lupus/Scleroderma/CREST	❑
❑	Heart attack/angina	❑	❑	Osteoporosis	❑
❑	Heart surgery/angioplasty	❑	❑	Joint replacement/fractures/falls	❑
❑	Cardiomyopathy	❑	❑	Paralysis/amputation/weakness	❑
❑	Congestive heart failure	❑	❑	Bladder/bowel incontinence	❑
❑	Hypertension	❑	❑	Numbness of extremities	❑
❑	Stroke/TIA	❑	❑	Tremor/imbalance/gait disturbance	❑
❑	Respiratory/lung condition(s)	❑	❑	Dizziness/fainting	❑
❑	Kidney/bladder condition(s)	❑	❑	Muscle disorder(s)	❑
❑	Liver condition(s)/hepatitis	❑	❑	Fibromyalgia	❑
❑	Diabetes/Endocrine condition(s)	❑	❑	Chronic fatigue syndrome	❑
❑	Neurological condition(s)	❑	❑	Polymyalgia rheumatica	❑
❑	Seizures/brain condition(s)/head injury	❑	❑	Memory loss/forgetfulness	❑
❑	Spine/back condition(s)	❑	❑	Ulcerative colitis/Crohns	❑
❑	Psychiatric condition(s)	❑	❑	Organ transplant	❑
❑	Depression/anxiety	❑	❑	Blindness	❑

A YES	A NO	Question	B YES	B NO
❑	❑	2. Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek medical advice?	❑	❑
❑	❑	3. **Within the past 12 months**, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, continuous positive airway pressure (CPAP)?	❑	❑
❑	❑	4. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?	❑	❑
❑	❑	5. Have you **ever** resided in, or used: a nursing home; an assisted living facility; adult day care; any other type of long-term care facility; or home health care services?	❑	❑
❑	❑	6. Have you **ever** had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?	❑	❑
❑	❑	7. Are you receiving any disability payments or worker's compensation?	❑	❑

_______________ **APPLICANT A** **APPLICANT B** _______________

PART D HEALTH QUESTIONS – *continued* (Provide additional information in the DETAILS section on page 6.)

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	8. Did you answer **YES** to any question 1-7? **IF YES** provide details below for **each** applicant (separately).	❑	❑

Select Applicant	Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)
❑A ❑B					
❑A ❑B					
❑A ❑B					
❑A ❑B					
❑A ❑B					
❑A ❑B					
❑A ❑B					

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	9. Have you taken any medications (excluding vitamins) or supplements **in the past 12 months?** **If YES** provide details below for **each** medication taken for **each** applicant (separately).	❑	❑

Select Applicant	Medication	Dosage/ Frequency	Reason For Taking	Name of Prescribing Health Professional
❑A ❑B				
❑A ❑B				
❑A ❑B				
❑A ❑B				
❑A ❑B				
❑A ❑B				

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	10. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) **in the past 2 years**? **IF YES** indicate date of last use. **APPLICANT A**______________ (mm/dd/yyyy) | **APPLICANT B** ______________ (mm/dd/yyyy)	❑	❑
❑	❑	11. Do you consume alcoholic beverages? **APPLICANT A** How often? ________ How much? ________ | **APPLICANT B** How often? ________ How much? ________	❑	❑
❑	❑	12. Have you **ever** been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? **IF YES** indicate date of last treatment. **APPLICANT A**______________ (mm/dd/yyyy) | **APPLICANT B** ______________ (mm/dd/yyyy)	❑	❑
❑	❑	13. Have you had a weight gain or loss of 10 pounds or more **in the past 12 months**? **If YES** please specify: **APPLICANT A** Pounds lost ______ Pounds gained______ | **APPLICANT B** Pounds lost ________ Pounds gained________	❑	❑
❑	❑	14. Do you work, volunteer or participate in hobbies or other activities outside your home? **If YES** please describe. **APPLICANT A** Position/Title ____________ Hours of Work/ Week ____________ Other activities ____________ | **APPLICANT B** Position/Title ____________ Hours of Work/ Week ____________ Other activities ____________	❑	❑

_______________ APPLICANT A APPLICANT B _______________

PART D HEALTH QUESTIONS – *continued*

DETAILS: Please use the space below to provide any additional information to your answers in Part D, including any other Physician Specialists you have seen **in the past 5 years.** Information provided on this page will become a part of the application and will be considered by MetLife in determining your eligibility for insurance.

APPLICANT A Dr. Info/ Ques. #	APPLICANT A Details	APPLICANT B Dr. Info/ Ques. #	APPLICANT B Details

PART E REPLACEMENT QUESTIONS (You MUST answer all questions or we will not be able to process this application.)

APPLICANT A YES	APPLICANT A NO	State regulations require that we ask the following questions if you are applying for insurance.	APPLICANT B YES	APPLICANT B NO
❑	❑	1. 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** coverage types/amounts? **APPLICANT A** ________ **APPLICANT B** ________	❑	❑
❑	❑	2. 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? **APPLICANT A** ________ **APPLICANT B** ________ If that policy or certificate lapsed, when did it lapse? **APPLICANT A** ________ (mm/dd/yyyy) **APPLICANT B** ________ (mm/dd/yyyy)	❑	❑
❑	❑	Is the policy in-force under a nonforfeiture benefit provision?	❑	❑
❑	❑	3. Are you covered under Medicaid? ("Medicaid" is different from "Medicare.")	❑	❑
❑	❑	4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? **IF YES** complete all information below and sign Replacement Notice on page 9. **APPLICANT A** Policy Number________ Insurance Company Name ________ Insurance Company Address ________ **APPLICANT B** Policy Number________ Insurance Company Name ________ Insurance Company Address ________	❑	❑

PART F PAYMENT SELECTIONS

APPLICANT A		APPLICANT B

Choose only ONE of the payment methods and modes below.
Please note there is an additional cost if you pay premiums more frequently than annually.

APPLICANT A			APPLICANT B
❑	Annual Direct Bill	Annual Direct Bill	❑
❑	Semi-Annual Direct Bill	Semi-Annual Direct Bill	❑
❑	Quarterly Direct Bill	Quarterly Direct Bill	❑

If you would like your bill sent to an address other than the address listed in Part A, please indicate below.

APPLICANT A	APPLICANT B
Name ______________________	Name ______________________
Address ______________________	Address ______________________
City ______________________	City ______________________
State __________ Zip __________	State __________ Zip __________
Phone Number ( ) ______________	Phone Number ( ) ______________

APPLICANT A			APPLICANT B
❑	Monthly Automatic Checking Account Deduction	Monthly Automatic Checking Account Deduction	❑

Electronic Payment Agreement Authorization

Your monthly premium will be deducted automatically from the bank or credit union checking account you request. **Enclose a <u>voided blank check</u> for the account you wish to use. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

APPLICANT A: Credit Union Phone Number ( ) ______________________

APPLICANT B: Credit Union Phone Number ( ) ______________________

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.

APPLICANT A : By signing below, 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.

APPLICANT B : By signing below, 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.

X ______________________________________ ______________________
Signature of Account Holder for **APPLICANT A** Date

X ______________________________________ ______________________
Signature of Account Holder for **APPLICANT B** Date

ATTACH VOIDED CHECK(S) HERE
DO NOT send deposit slips.

PART G AGREEMENT AND ACKNOWLEDGEMENT

APPLICANT A		APPLICANT B
	Required Information. Please check to indicate that you have received all of the following items:	
❑ ❑ ❑ ❑ ❑	Privacy Notice Rate Disclosure Form Outline of Coverage Shopper's Guide to Long-Term Care Insurance Replacement Notice (if this is a replacement policy)	
	Privacy Notice Rate Disclosure Form Outline of Coverage Shopper's Guide to Long-Term Care Insurance Replacement Notice (if this is a replacement policy)	❑ ❑ ❑ ❑ ❑

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.

Applicant A:

❑ **I do NOT elect to designate any person to receive such notice.**

❑ **I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:**

Name ______________________
Address ______________________
City______________________
State ______________ Zip ________
Phone Number ( ) ______________________
Relationship ______________________

Applicant B:

I do NOT elect to designate any person to receive such notice. ❑

I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium: ❑

Name ______________________
Address ______________________
City______________________
State ______________ Zip ________
Phone Number ( ) ______________________
Relationship ______________________

❑ **Rejection of 5% Automatic Compound Inflation Protection Rider** (if applicable) ❑
I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection Rider.

X ______________________ **X** ______________________
Signature of **APPLICANT A** Date Signature of **APPLICANT B** Date

❑ **Rejection of Nonforfeiture Coverage Rider** (if applicable) ❑
I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider.

X ______________________ **X** ______________________
Signature of **APPLICANT A** Date Signature of **APPLICANT B** Date

Your signature at the end of this section (Agreement and Acknowledgement) confirms the following:

I understand that 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 modal premium amount 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 all statements made on this application are representations and not warranties. 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, in writing, 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 at the end of this section.

PART G AGREEMENT AND ACKNOWLEDGEMENT – *continued*

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.

Caution: If your answers or statements on this application are misstated or untrue, or fail to include all material medical information requested, MetLife may have the right to deny benefits or rescind your coverage.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your signature below: Confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected 5% Automatic Compound Inflation Protection Rider, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection Rider and your rejection of 5% Automatic Compound Inflation Protection Rider.

X ______________________________
Signature of **APPLICANT A**

____
Date Signed at City, State

X ______________________________
Signature of Licensed and Appointed Agent/Producer

____
Date Signed at City, State

X ______________________________
Signature of **APPLICANT B**

____
Date Signed at City, State

X ______________________________
Signature of Licensed and Appointed Agent/Producer

____
Date Signed at City, State

LTC4APP-IND-CT

REPLACEMENT NOTICE (Complete this section for replacement policies only.)

If Part E, question #4 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 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/PRODUCER: (Use additional sheets as necessary.) I have reviewed your current medical, health, and long-term care 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 long-term care insurance coverage, you may wish to secure the advice of your present insurer or its Agent/Producer 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.

X ______________________________
Signature of Licensed and Appointed Agent/Producer

____
Print Name of Licensed and Appointed Agent/Producer

____
Address of Licensed and Appointed Agent/Producer

X ______________________________
Signature of **APPLICANT A** Date

X ______________________________
Signature of **APPLICANT B** Date

APPLICANT A

MEDICAL AUTHORIZATION

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about me relating to mental illness, other than psychotherapy notes; and
- the company to request and obtain consumer reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 937, Westport, CT 06881-0937 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

________________________________ ____________________
Print Name of **APPLICANT A** Date of Birth

X ________________________________ ____________________
Signature of **APPLICANT A** Date

APPLICANT B

MEDICAL AUTHORIZATION

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about me relating to mental illness, other than psychotherapy notes; and
- the company to request and obtain consumer reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 937, Westport, CT 06881-0937 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

______________________________ ____________________

Print Name of **APPLICANT B** Date of Birth

X ______________________________ ____________________

Signature of **APPLICANT B** Date

APPLICANT A

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO AGENT/PRODUCER

I authorize Metropolitan Life Insurance Company ("MetLife") to disclose information about me, including health related information, to my insurance Agent/Producer named below for the purpose of providing me with additional information regarding my underwriting classification for this insurance.

____

Print Name of Licensed and Appointed Agent/Producer

____

Print Address of Licensed and Appointed Agent/Producer

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include all health related records about me, which may contain records, test results, and data on my medical care, treatment or surgery; prescription medicines; sexually transmitted diseases, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS) and HIV related conditions; mental illness, psychiatric or psychological medical records (but not psychotherapy notes); and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws.

In no event will information regarding your health history be disclosed if prohibited by state or federal law.

I understand that:

- **I am not required to sign this Authorization as a condition to my application for long-term care insurance from MetLife.**
- Information disclosed pursuant to this Authorization may no longer be subject to MetLife's privacy policy.
- Information that may have been subject to 42 CFR Part 2 or HIPAA privacy rules or other laws, once disclosed, will no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- I have a right to revoke this Authorization at any time and may do so by writing to MetLife, P.O. Box 937, Westport, CT 06881-0937. I further understand, however, that any action taken by MetLife in reliance on this Authorization prior to receipt of my revocation by MetLife will remain valid.
- This Authorization will be valid for 6 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to receive a copy of this Authorization.

A copy of this Authorization will be as valid as the original.

X ____ ________________

Signature of **APPLICANT A** Date

____

Print Name of **APPLICANT A**

____

Address

APPLICANT B

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO AGENT/PRODUCER

I authorize Metropolitan Life Insurance Company ("MetLife") to disclose information about me, including health related information, to my insurance Agent/Producer named below for the purpose of providing me with additional information regarding my underwriting classification for this insurance.

____

Print Name of Licensed and Appointed Agent/Producer

____

Print Address of Licensed and Appointed Agent/Producer

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include all health related records about me, which may contain records, test results, and data on my medical care, treatment or surgery; prescription medicines; sexually transmitted diseases, Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS) and HIV related conditions; mental illness, psychiatric or psychological medical records (but not psychotherapy notes); and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws.

In no event will information regarding your health history be disclosed if prohibited by state or federal law.

I understand that:

- **I am not required to sign this Authorization as a condition to my application for long-term care insurance from MetLife.**
- Information disclosed pursuant to this Authorization may no longer be subject to MetLife's privacy policy.
- Information that may have been subject to 42 CFR Part 2 or HIPAA privacy rules or other laws, once disclosed, will no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- I have a right to revoke this Authorization at any time and may do so by writing to MetLife, P.O. Box 937, Westport, CT 06881-0937. I further understand, however, that any action taken by MetLife in reliance on this Authorization prior to receipt of my revocation by MetLife will remain valid.
- This Authorization will be valid for 6 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to receive a copy of this Authorization.

A copy of this Authorization will be as valid as the original.

X ____ ________________

Signature of **APPLICANT B** Date

____

Print Name of **APPLICANT B**

____

Address

APPLICANT A

LTC BENEFICIARY DESIGNATION FORM FOR PAYMENTS ON DEATH

Applicant's Name:________________________________ Applicant's Social Security No:__________________________

Please make sure to check only one of the following three designees and complete all accompanying information requested.

By completing this Beneficiary Designation Form, I hereby revoke any previous beneficiary designation and name the following beneficiary to receive, upon my death, any portion of benefits payable or premium to be refunded pursuant to the terms of my Long-Term Care Insurance policy:

❑ **Individual Beneficiary(ies) Designation**

Full Name (Last, First, Middle Initial)	Relationship	Social Security Number	Date of Birth	Address (Street, City, State, Zip)	Telephone Number	Primary Share %	Contingent Share %
❑ Primary							
❑ Primary ❑ Contingent							
❑ Primary ❑ Contingent							
					Total	100%	

Payment will be made in equal shares unless otherwise indicated. In the event that one or more beneficiary(ies) predeceases the insured, the share(s) of such deceased beneficiary(ies) will be distributed equally among the surviving beneficiaries, unless otherwise indicated.

If this form is executed by the insured, it is understood and agreed that if Metropolitan Life Insurance Company (MetLife) receives proof satisfactory to it that the designation of individual beneficiary(ies) above has been revoked, or that no beneficiary designated is living upon the insured's death, the beneficiary shall be the insured's estate.

❑ **Trust(ee) Designation** (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) ____

Address ___________________________ City__________________ State _______ Zip Code__________

and successor(s) in trust, as Trustee(s) under ____________________________________
(Title of the Trust Agreement)

dated ______________________ and executed by me and said Trustee(s).
(Date of the Trust Agreement)

If this form is executed by the insured, it is understood and agreed that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect upon the insured's death, the beneficiary shall be the insured's estate.

❑ **Trust(ee) (Under Will) Designation** (applies only if a trust has been set forth in your Will). The Trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If this form is executed by the insured, it is understood and agreed that if, for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, the beneficiary shall be the insured's estate.

I understand and agree that any payment made in good faith by MetLife to the beneficiary designated by me on this form, or to the legal representative of my estate pursuant to the terms of this form, shall be full discharge of the liability of MetLife under the Payments on Death provision of my Long-Term Care Insurance policy. Further, I understand that the Return of Earned Premium on Death benefit under my Long-Term Care Insurance policy cannot be assigned, borrowed or pledged as collateral for a loan. I reserve the right to change the beneficiary(ies) designated on this form at any time without (his/her/their) consent, by completing and submitting to MetLife a new Beneficiary Designation Form available by calling (888) 565-3761.

__________________________ X______________________________ ______________
Print Name of **APPLICANT A** Signature of **APPLICANT A** Date

APPLICANT B

LTC BENEFICIARY DESIGNATION FORM FOR PAYMENTS ON DEATH

Applicant's Name:__________________________________ Applicant's Social Security No:__________________________

Please make sure to check only one of the following three designees and complete all accompanying information requested.

By completing this Beneficiary Designation Form, I hereby revoke any previous beneficiary designation and name the following beneficiary to receive, upon my death, any portion of benefits payable or premium to be refunded pursuant to the terms of my Long-Term Care Insurance policy:

❑ **Individual Beneficiary(ies) Designation**

Full Name (Last, First, Middle Initial)	Relationship	Social Security Number	Date of Birth	Address (Street, City, State, Zip)	Telephone Number	Primary Share %	Contingent Share %
❑ Primary							
❑ Primary ❑ Contingent							
❑ Primary ❑ Contingent							
					Total	**100%**	

Payment will be made in equal shares unless otherwise indicated. In the event that one or more beneficiary(ies) predeceases the insured, the share(s) of such deceased beneficiary(ies) will be distributed equally among the surviving beneficiaries, unless otherwise indicated.

If this form is executed by the insured, it is understood and agreed that if Metropolitan Life Insurance Company (MetLife) receives proof satisfactory to it that the designation of individual beneficiary(ies) above has been revoked, or that no beneficiary designated is living upon the insured's death, the beneficiary shall be the insured's estate.

❑ **Trust(ee) Designation** (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) ____

Address ____________________________ City __________________ State ________ Zip Code____________

and successor(s) in trust, as Trustee(s) under ____
(Title of the Trust Agreement)

dated _______________________ and executed by me and said Trustee(s).
(Date of the Trust Agreement)

If this form is executed by the insured, it is understood and agreed that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect upon the insured's death, the beneficiary shall be the insured's estate.

❑ **Trust(ee) (Under Will) Designation** (applies only if a trust has been set forth in your Will). The Trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If this form is executed by the insured, it is understood and agreed that if, for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, the beneficiary shall be the insured's estate.

I understand and agree that any payment made in good faith by MetLife to the beneficiary designated by me on this form, or to the legal representative of my estate pursuant to the terms of this form, shall be full discharge of the liability of MetLife under the Payments on Death provision of my Long-Term Care Insurance policy. Further, I understand that the Return of Earned Premium on Death benefit under my Long-Term Care Insurance policy cannot be assigned, borrowed or pledged as collateral for a loan. I reserve the right to change the beneficiary(ies) designated on this form at any time without (his/her/their) consent, by completing and submitting to MetLife a new Beneficiary Designation Form available by calling (888) 565-3761.

____________________________ **X**________________________________ ______________
Print Name of **APPLICANT B** Signature of **APPLICANT B** Date

_______________ APPLICANT A APPLICANT B _______________

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they receive. Others don't want their family to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.
By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

PREMIUM INFORMATION

Policy Form Number: LTC2007

The premium for the coverage you are considering will be:

Premium Rate: The following premium rate is applicable to you and will be in effect until a request for an increase is made and filed with your state Insurance Department (choose one for each applicant):

APPLICANT A ❑ $________ per month, or ❑ $ _________per quarter, or ❑ $ _________semi-annually, or ❑ $ ________annually

APPLICANT B ❑ $________ per month, or ❑ $ _________per quarter, or ❑ $ _________semi-annually, or ❑ $ ________annually

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History: The company has sold long-term care insurance since 1986, and has sold this policy since 2007. MetLife has not raised premium rates for this policy form or any other MetLife individual long-term care insurance policy form, which has already been sold in this state or any other state. However, MetLife has obtained approval in this and other states to apply a new premium rate schedule to this policy form, as well as to another individual long-term care policy form currently sold by MetLife, and has implemented these new premium rate schedules where already approved. Please note that these new premium rate schedules do not apply to any individual whose coverage was effective prior to implementation of these new premium rate schedules in that state.

With respect to policies which have already been sold, MetLife has only increased its rates for long-term care insurance covering residents of a Continuing Care Retirement Community (CCRC), the details of which appear in the chart below:

Policy Form	Years Available	Year(s) of Increase	Percentage of Increase
#G.9873	1989-98	1999	9-38%

QUESTIONS RELATED TO YOUR INCOME

How will you pay each year's premium? (check one)

APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay

APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

---

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

APPLICANT A ❑ Yes ❑ No

APPLICANT B ❑ Yes ❑ No

What is your annual income? (check one)

APPLICANT A ❑ Under $10,000 ❑ $10,000 - $19,999 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

APPLICANT B ❑ Under $10,000 ❑ $10,000 - $19,999 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

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

APPLICANT A ❑ No change ❑ Increase ❑ Decrease

APPLICANT B ❑ 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.

Will you buy inflation protection? (check one)

APPLICANT A ❑ Yes ❑ No

APPLICANT B ❑ Yes ❑ No

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET – *continued*

QUESTIONS RELATED TO YOUR INCOME (Continued)

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay

APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

The national average annual cost of Nursing Home care in 2006 was $66,795, but this figure varies across the country. In ten years the national average annual cost would be about $108,802 if costs increase 5% annually.

What elimination period are you considering?

APPLICANT A 100 Number of days $ __________ Approximate cost for that period of care

APPLICANT B 100 Number of days $ __________ Approximate cost for that period of care

How are you planning to pay for your care during the elimination period? (check one)

APPLICANT A ❑ From my income ❑ From my savings/investments ❑ My family will pay

APPLICANT B ❑ From my income ❑ From my savings/investments ❑ My family will pay

QUESTIONS RELATED TO YOUR SAVINGS/INVESTMENTS

Not counting your home, about how much are all of your assets worth (your savings and investments)? (check one)

APPLICANT A ❑ Under $20,000 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

APPLICANT B ❑ Under $20,000 ❑ $20,000 - $29,999 ❑ $30,000 - $50,000 ❑ Over $50,000

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

APPLICANT A ❑ Stay about the same ❑ Increase ❑ Decrease

APPLICANT B ❑ 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.

DISCLOSURE STATEMENT

APPLICANT A		APPLICANT B
❑ ❑	**(Each applicant MUST check one):** The answers to the questions above describe my financial situation **OR** I choose not to complete this information.	❑ ❑
❑	**(This box must be checked.)** I acknowledge that the carrier and/or its Agent/Producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. **I understand the above disclosures. I understand that the rates for this policy may increase in the future.** X ______________________ X ______________________ Signature of **APPLICANT A** Date Signature of **APPLICANT B** Date	❑
❑	**AGENT/PRODUCER** I explained to the applicant the importance of completing this information. X ______________________ X ______________________ Print Name of Licensed & Appointed Agent/Producer Signature of Licensed & Appointed Agent/Producer Date **In order for us to process your application, please return this signed statement to MetLife, along with your application.**	❑
❑	My Agent/Producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application. X ______________________ X ______________________ Signature of **APPLICANT A** Date Signature of **APPLICANT B** Date The company may contact you to verify your answers.	❑

AUTHORIZATION TO PROCEED PROCESSING APPLICATION

If the applicant elects not to complete the Long-Term Care Insurance Personal Worksheet, this form must be completed and submitted with the application and the signed Long-Term Care Insurance Personal Worksheet in order to process the application.

TO: Long-Term Care Division, Metropolitan Life Insurance Company

Re: Financial Suitability of the purchase of Long-Term Care Insurance

I am applying for long-term care insurance. My Agent/Producer has explained to me that my financial situation is an important consideration as to whether or not long-term care insurance is an appropriate purchase for me.

My Agent/Producer has also explained the importance of completing the Long-Term Care Insurance Personal Worksheet. This information can help me determine whether I should purchase long-term care insurance and can afford to pay the required premium.

I hereby confirm that I choose not to complete the financial information on the Long-Term Care Insurance Personal Worksheet. Nevertheless, I request that you continue to process my application for long-term care insurance coverage.

X ______________________________ ______________________

Signature of **APPLICANT A** Date

X ______________________________ ______________________

Signature of **APPLICANT B** Date

CONDITIONAL PREMIUM RECEIPT

Received from ______________________________ Name of **APPLICANT A** (Please print) $______________ on ____________ Check No. ________ Amount Date	Received from ______________________________ Name of **APPLICANT B** (Please print) $______________ on ____________ Check No. ________ 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. **In the event that all of the conditions in the preceding sentence are satisfied, coverage under this Conditional Receipt will take effect on the Application Date and the coverage shall be governed by the terms and conditions of the policy applied for in the application.** 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 C 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 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/Producer, 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.

I have read this Conditional Premium Receipt, and reviewed my answers to all questions in 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 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.

X ____________________________ ____________ Signature of **APPLICANT A** Date No Agent/Producer 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 C of your application. Receipt of $ ________ is acknowledged from __________ in connection with the application for Long-Term Care Insurance on this date ________ By: **X** ______________________________________ Signature of Licensed & Appointed Agent/Producer	**X** ____________________________ ____________ Signature of **APPLICANT B** Date No Agent/Producer 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 C of your application. Receipt of $ ________ is acknowledged from __________ in connection with the application for Long-Term Care Insurance on this date ________ By: **X** ______________________________________ Signature of Licensed & Appointed Agent/Producer

Gwenn L. Carr

Gwenn L. Carr, Senior Vice-President and Secretary, Metropolitan Life Insurance Company

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/PRODUCER OR LEAVE THE PAYEE BLANK.**

_______________ APPLICANT A   APPLICANT B _______________

AGENT/PRODUCER'S REPORT (Please provide complete details to ensure against delays in processing this application.)

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	1. Did you personally interview the Applicant face to face and witness his or her signature? **IF NO** give details: **APPLICANT A** ______________________ **APPLICANT B** ______________________	❑	❑
❑	❑	2. If you answered **YES** to question 1, did you observe any physical or mental impairments with regard to the Applicant's walking or talking, or any form of tremor? **IF YES** please describe: **APPLICANT A** ______________________ **APPLICANT B** ______________________	❑	❑
		3. Is special consideration needed for (check all that apply): **APPLICANT A** ❑ Hearing Impairment ❑ Language Translation Please explain: ______________________ **APPLICANT B** ❑ Hearing Impairment ❑ Language Translation Please explain: ______________________		
		4. Please list other health insurance policies sold by you to the Applicant that are still in-force: **APPLICANT A** ______________________ **APPLICANT B** ______________________		
		5. List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force: **APPLICANT A** ______________________ **APPLICANT B** ______________________		
❑	❑	6. Did the Agent/Producer/Agency order the APS? **IF YES** include a copy of the order form. **APPLICANT A** Physician Name: ______________________ Vendor ______________ Date Ordered: ______________ mm/dd/yyyy **APPLICANT B** Physician Name: ______________________ Vendor ______________ Date Ordered: ______________ mm/dd/yyyy	❑	❑
❑	❑	7. Is this a replacement policy? (**IF YES** complete the Replacement Notice on page 9.)	❑	❑
		APPLICANT A 8. Modal Premium $ ______________ Annualized Premium $ ______________ **APPLICANT B** Modal Premium $ ______________ Annualized Premium $ ______________ Underwriting: I have reviewed the underwriting guidelines and the information provided in this application. The following risk class was quoted to the Applicant (check only one): **APPLICANT A** ❑ Standard ❑ Preferred **APPLICANT B** ❑ Standard ❑ Preferred		
❑	❑	9. Have you delivered the Compensation Disclosure Notice to the Applicant (only required for business sold by Agency Distribution Group (METLIFE and NEF), MLR, and MetLife Auto and Home sales representatives)?	❑	❑

AGENT/PRODUCER'S REPORT – *continued*

10. **CERTIFICATION** (Check one):

❑ I certify that each applicable question was personally asked of the Applicant(s) by me and that I have accurately recorded the information supplied by the Applicant(s). The Applicant(s) was interviewed by me in person or by telephone and all answers on this application are correct and complete to the best of my knowledge and belief. I certify that any required written disclosure statement was given to the Applicant(s) no later than the date this application was signed. I am certified to represent and sell this MetLife Long-Term Care approved product. (This includes any licenses, appointments, CE's, or Partnership certifications.)

❑ I did not personally interview, by phone or face-to-face, the Applicant(s). I certify that any required written disclosure statement was given to the Applicant(s) no later than the date this application was signed.

Print Name of Primary Licensed & Appointed Agent/Producer ______________________

Signature of Primary Licensed & Appointed Agent/Producer ______________________

Offered through: ❑ MetLife ❑ NEF ❑ MLR ❑ General Agent/Producer ❑ Other ____________ Firm Name

Office ID# ____________ Producer # ____________ SS# ____________

For MetLife and NEF: Please indicate address to send policies and correspondence.

Address ____________ City ____________ State ______ Zip ______

Phone/Fax ( ) ____________ E-mail address ____________

11. **For split commission cases, provide the information requested below, indicating the percentage of commission applicable to each: (Percentage column must total 100%. Use only whole numbers. Each Rep listed must receive at least 1%).**

REP NAME	AGENCY #/ FIRM NAME	PRODUCER #	SS#	PERCENT	DISTRIBUTION CHANNEL*

Please identify the distribution channel you are submitting business under:* **• MetLife • NEF • MLR • General Agent/Producer-LTC Brokerage • Other

YOU MUST COMPLETE THIS SECTION IF YOU ARE SUBMITTING BUSINESS THROUGH LTC BROKERAGE.

Please read and complete the following certification: For purposes of determining whether commission or other compensation relating to the sale of MetLife Long-Term Care Insurance ("LTCI") may be paid or assigned based on an entity's licensing status in a particular state, I understand that MetLife needs to know whether the above entity will be involved with applicants in selling, soliciting or negotiating MetLife LTCI. The undersigned certifies that the entities checked will not be involved with applicants in selling, soliciting or negotiating MetLife LTCI and will not be known to the applicants for the LTCI: ❑ MGA ❑ AGA ❑ GA1 ❑ Payee

MGA Name ____________ MGA Code ____________ MGA contact (for application status) ____________

MGA Address ____________ E-mail (for application status) ____________

MGA Phone Number ( ) ____________ Fax Number ( ) ____________

Agent/Producer's Name ____________ E-mail address ____________

Agent/Producer's Address ____________ Agent/Producer's Phone Number ( ) ____________

BROKER HIERARCHY: Please list GA1 and AGA name(s) and code(s) if the broker does not roll up directly to the MGA.

IF SPLIT

AGA ____________ AGA ____________

GA1 ____________ GA1 ____________

Broker ____________ Broker ____________

Enter "pending" if code not yet assigned.

Metropolitan Life Insurance Company
New York, NY

order #:
LTC4APP-IND-CT (0310)

MetLife®

Individual Long-Term Care Insurance (LTCI)
Client Packet for Applicants A and B

IMPORTANT DOCUMENTS

Regarding Your Application for Long-Term Care Insurance

Table of Contents

MetLife LTC LifeStage Advantage℠

Metropolitan Life Insurance Company ("MetLife"), New York, NY

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 thoroughly and make sure you understand what it covers before you purchase.

- You should **not** purchase this policy unless you can afford to pay the premiums every year. Remember that the company may 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 is **not** designed to pay for long-term care.

MEDICAID

Medicaid will generally pay for long-term care services if you have very little income and few assets. If you are now eligible for Medicaid, you should not purchase this policy.

- Many people become eligible for Medicaid after they have exhausted their own financial resources 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/Producer 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 receive a full refund of any premium you had 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 is 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.

FACILITIES

Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what type of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM

PREMIUM RATE

The following premium rate is applicable to you and will be in effect until a request for an increase is made and is filed (and approved in those states that require approval) by your state Insurance Department: (choose one)

APPLICANT A ❑ $ ________ per month, or ❑ $ ________ per quarter, or ❑ $ ________ semi-annually, or ❑ $ ________ annually

APPLICANT B ❑ $ ________ per month, or ❑ $ ________ per quarter, or ❑ $ ________ semi-annually, or ❑ $ ________ annually

The premium for this policy will be shown on the schedule of benefits page of your policy.

RATE SCHEDULE ADJUSTMENTS

Premium rate or rate schedule adjustments will be effective the first billing date that occurs on or after 45 days following notification of a rate adjustment.

POTENTIAL RATE REVISION

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can not be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase as a nonforfeiture coverage rider for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase the Nonforfeiture Coverage Rider, or if you purchase the Nonforfeiture Coverage Rider and it does not apply.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy the Nonforfeiture Coverage Rider, or the Nonforfeiture Coverage Rider does not apply, you may be eligible for contingent nonforfeiture (referred to as "Contingent Benefit Upon Lapse" in the policy). Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e. new Total Benefit Amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining Total Benefit Amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining Total Benefit Amount.

Except for this reduced Total Benefit Amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this contingent nonforfeiture option, your policy, with this reduced Total Benefit Amount, will be considered "paid-up" with no further premiums due.

EXAMPLE

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.
- In the eleventh year, you receive a rate increase of 50% or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM – *continued*

CONTINGENT NONFORFEITURE

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture *(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)*

ISSUE AGE	PERCENT INCREASE OVER INITIAL PREMIUM	ISSUE AGE	PERCENT INCREASE OVER INITIAL PREMIUM
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

PRD07

REPLACEMENT NOTICE

(Complete this section for replacement policies only.)

If Part E, question #4 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 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/PRODUCER: (Use additional sheets as necessary.) I have reviewed your current medical, health, and long-term care 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 long-term care insurance coverage, you may wish to secure the advice of your present insurer or its Agent/Producer 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.

X ______________________________
Signature of Licensed and Appointed Agent/Producer

X ______________________________
Signature of **APPLICANT A** Date

____
Print Name of Licensed and Appointed Agent/Producer

____
Address of Licensed and Appointed Agent/Producer

X ______________________________
Signature of **APPLICANT B** Date

PRIVACY NOTICE

If you submit a request for insurance (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.

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.) We are required by law to give you this notice.

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. Our affiliates currently include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

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

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

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

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

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

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.

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 comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

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 a group customer about its members' claims or cooperating in a group customer's audit of our service;
- 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 insurance or benefits

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.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- If you are a dental, long term care, or health plan customer; we will not market to you without your consent based on what we know about you related to that coverage.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

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.

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. For example, individuals who have dental, long term care, or health insurance coverage from us have certain rights under the federal Health Insurance Portability and Accountability Act (HIPAA). You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. Select "Privacy Policy" at the bottom of the home page. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyInst@MetLife.com. You may also write to the MetLife Long-Term Care HIPAA Coordinator, P.O. Box 937, Westport, Connecticut 06881-0937.

If you want to know more about our privacy policy, please visit our website, www.MetLife.com. Also, you may write to the MetLife Long-Term Care Privacy Coordinator, P.O. Box 937, Westport, Connecticut 06881-0937.

CONDITIONAL PREMIUM RECEIPT

Received from ______________________________
Name of **APPLICANT A** (Please print)

$______________ on ______________ Check No. _________
Amount Date

Received from ______________________________
Name of **APPLICANT B** (Please print)

$______________ on ______________ Check No. _________
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. **In the event that all of the conditions in the preceding sentence are satisfied, coverage under this Conditional Receipt will take effect on the Application Date and the coverage shall be governed by the terms and conditions of the policy applied for in the application.** 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 C 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 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/Producer, 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.

I have read this Conditional Premium Receipt, and reviewed my answers to all questions in 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 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.

X ______________________________ ____________
Signature of **APPLICANT A** Date

No Agent/Producer 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 C of your application.

Receipt of $ _________ is acknowledged from ___________ in connection with the application for Long-Term Care Insurance on this date _________ By:

X ______________________________
Signature of Licensed & Appointed Agent/Producer

X ______________________________ ____________
Signature of **APPLICANT B** Date

No Agent/Producer 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 C of your application.

Receipt of $ _________ is acknowledged from ___________ in connection with the application for Long-Term Care Insurance on this date _________ By:

X ______________________________
Signature of Licensed & Appointed Agent/Producer

Gwenn L. Carr

Gwenn L. Carr, Senior Vice-President and Secretary, Metropolitan Life Insurance Company

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/PRODUCER OR LEAVE THE PAYEE BLANK.**

Metropolitan Life Insurance Company
New York, NY

0705-4676

order #:
LTC4APP-IND-CL (1107)