

Application for Change in Coverage or Reinstatement

Attention: _____

Type of Change

- Change to the elimination period
- Change to the benefit period
- Upgrade an Occupational Class
- Apply for a tobacco user status change
- Apply for reconsideration of an exclusion rider or rating
- Remove an optional benefit
- Add an optional benefit
- Change monthly benefit
- Address change
- Exchange or convert policy
- Convert to level premium policy
- Exercise the Guaranteed Insurability Option
- Other

Additional Information: _____

Contact at Sales Office

Name: _____ Phone: _____

E-mail: _____ Fax: _____



Application for Change in Coverage or Reinstatement

Part I

A

Name of Insured: _____ Policy Number: _____

Residence Address: _____
(Street) (City) (State) (Zip Code)

Phone Number: () _____ - _____

Address Change: Yes No Effective date of address change: _____

New Address: _____

B

Elimination Period / Maximum Benefit Period Change Requires Completion of Part II and III if you are applying to decrease the Elimination Period and/or extend the Benefit Period.

Change Elimination Period from: _____ To _____

Change Maximum Benefit Period from: _____ To _____

C

Reduce Monthly Benefit

Reduce Monthly Benefit Amount from: \$ _____ To \$ _____

D

Reconsider Rating/Exclusion Rider Requires Completion of Part III

Give details of rated condition or indicate the condition that is excluded from the existing policy.

Have you had any symptoms or have you been treated for this condition since the policy was issued? Yes No

If yes, give details:

Date of last symptom or treatment: _____

Name, Address and Phone number of Physician: _____



E Exchanges

1.) Business Overhead Expense (Policy Number) _____ to Level Premium Policy with the following:
 Elimination Period _____ Maximum Benefit Period _____ Monthly Benefit Amount _____

2.) Priority Plus (or Annually Renewable Disability Income) Policy Number _____ to Level Premium Policy with the following:
 Elimination Period _____ Maximum Benefit Period _____ Monthly Benefit Amount _____
 Details:

F Remove Smoker Rating

Have you smoked or used tobacco in any form for the past 12 months? Yes No

Date Last Used: _____ Type: _____

G Add or Remove the Following Optional Benefits from Policy Number _____ AH

Adding Optional Benefits (except for the Good Health Benefit) requires completion of Part II and Part III.

List Optional Benefits to be removed:

List Optional Benefits to be added:

H Reinstatement (Requires Completion of Part II and Part III)

Policy Number: _____ Date Lapsed: _____

Part II

1. (a) Occupation _____

(b) Are you currently working at least 30 hours per week in this occupation? Yes No
 If "no", give details: _____

(c) Name and address of Employer: _____

(d) Job duties and % of time spent at each duty

_____	%
_____	%
_____	%
_____	%

(e) Do you engage in any part time occupation? Yes No If "yes", give details: _____

2. Do you own or share ownership of the above business? Yes _____% No

3. How is the business organized? Sole Proprietor Partnership LLP PC C Corp S Corp LLC PA



Financial Information

4. List the appropriate amounts as reported on your federal tax returns:

	<u>Current Year</u>	<u>Last Year</u>	<u>2 Yrs Ago</u>
Employee/Salaried Earnings			
Base Salary (W-2 Income)	\$ _____	\$ _____	\$ _____
Commissions	\$ _____	\$ _____	\$ _____
Bonus, Profit Sharing or Incentive payments	\$ _____	\$ _____	\$ _____
Owner/Shareholder earnings			
Sole Proprietor net business earnings/losses	\$ _____	\$ _____	\$ _____
Partnership/S Corp net business earnings/losses	\$ _____	\$ _____	\$ _____
Net share of corporate earnings/losses	\$ _____	\$ _____	\$ _____
Total Earned Income			
Dividends and Interest	\$ _____	\$ _____	\$ _____
Net rental income before depreciation	\$ _____	\$ _____	\$ _____
Other (identify source)	\$ _____	\$ _____	\$ _____

5. Net Worth

Does your net worth exceed \$3,000,000? Yes No (if "yes", give details below.)

Cash, savings, stock, & bonds	\$ _____
Personal property (such as jewelry, furnishings)	\$ _____
Personal Residence	\$ _____
Other Real Estate	\$ _____
Business Interest (s)	\$ _____
Other (specify source)	\$ _____
Less: Indebtedness	\$ _____
Total	\$ _____

6. Disability Coverage in force or applied for:

Company	Type*	Year Issued	Amount of Monthly Benefit	Elimination Period	Maximum Benefit Period
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____
_____	_____	_____	\$ _____	_____	_____

*Type – G = Group, I = Individual, A = Association

7. Since the original application has any life, disability or health insurance been rated, modified, rejected, cancelled or not renewed?

Yes No If "yes", give details: _____



Part III

1. Current a) Height _____ b) Weight: _____
2. Date you last used tobacco in any form: Date _____ Type _____ Never used tobacco
3. How much time have you lost from work during the past 5 years because of accident or sickness? _____
(Give Details in question 8 below)
4. **Have you EVER** received treatment, attention, or advice for; been told that you had; or had any known indication of:

a) Any disease or disorder of the heart; arteries or veins; chest pains; elevated (high) blood pressure (hypertension)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Arthritis; any disease, disorder or deformity of the bones, muscles, tendons, or joints, including the spine; any neck or back problems or disorders; carpal tunnel syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Any mental, nervous or emotional problem, condition or disorder, including anxiety, depression or stress?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Stroke, embolism, thrombosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Cancer, tumor or polyp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Diabetes or high blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Any disease or disorder of the lungs or respiratory system, including asthma, allergy, emphysema, or Chronic Obstructive Pulmonary Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Any disease or disorder of the liver, gall bladder, pancreas, digestive tract, including intestines; ulcer, colitis, hemorrhoids, or hernia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Memory loss, loss of concentration, fatigue, neurological disorder, unconsciousness, loss of cognition, dizziness, paralysis or numbness, impairment of nervous system, epilepsy, or seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Any disease or disorder of the urinary tract or kidney; sugar, albumin or blood in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Any sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Any physical deformity or physical impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Any disease or disorder of glands; anemia, leukemia or other blood disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) Any disease or disorder of the prostate or testes (if male); uterus, ovaries or breasts (if female)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o) Any disease or disorder or impairment of the eyes or ears, mouth, nose, throat; any loss of vision or hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
p) Endocrine disorders or goiter or disease or disorder of the thyroid gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No
q) Adult Attention Deficit Disorder, Adult Attention Deficit Hyperactivity Disorder, Alzheimer's Disease, Chronic Fatigue Syndrome, Epstein-Barr Virus, Fibromyalgia, Lyme Disease, Myalgia or Encephalitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. **Have you ever** been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or other immune deficiency? Yes No

6. **Have you EVER:**

a) Been advised to have any medical test or surgical operation that was not performed, or had any medical test or surgical operation performed, or gone to a hospital, doctor's office, clinic, dispensary or sanatorium for observation, examination or treatment; and this information has not been revealed by previous questions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Been advised to modify or restrict eating, drinking or living habits because of any health conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Had persistent cough, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of 10 pounds or more, swollen glands?	<input type="checkbox"/> Yes <input type="checkbox"/> No



7. Please answer the following, providing applicable details for each “yes” answer.

a) Are you currently disabled, or do you expect to be disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Have you received or applied for disability, workers’ compensation, or military disability benefits from any source in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Within the last 5 years, have you taken any prescription medications, over the counter herbal medications, or been advised by a physician to take any medications, or are you now taking any prescription medications or over the counter herbal medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) If female, are you currently pregnant? If “yes”, expected date of delivery _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Please give details below to question 3, and to sections answered “yes” in questions 4 through 7 (state question #).

Question #	Date(s)	Doctor’s Name	Doctor’s Address	Doctor’s Phone #	Treatment	Medications



Agreement

I have read this application and any supplemental applications or amendments, and to the best of my knowledge and belief, I agree that: (a) All statements and answers are true and complete; (b) All of the information is correctly recorded in the application; and (c) Such written statements may be relied on by MetLife in order to determine if I qualify: (i) To have my policy reinstated; or (ii) For a coverage change.

I understand that the application seeks full disclosure of the information sought; and that no one has the right to alter or exclude or to direct me to alter or exclude any information from the application.

I understand that this application, any paramedical application, and any supplemental applications or amendments will become a part of any policies reinstated or changed as a result of this application.

Misstatements in this Application – I understand that, after this coverage has been in force during my lifetime for 2 years from the date of policy change or reinstatement, misstatements, except for fraudulent misstatements, made by me in this application for change in coverage or reinstatement cannot be used to void the policy change or reinstatement or to deny a claim under the policy change or reinstatement for a loss incurred or a disability that begins more than 2 years after the date of the policy change or reinstatement.

I understand that: (a) the reinstatement that I am applying for will not take effect and MetLife will have no liability; or (b) any coverage change that I am applying for will not be effective, unless on the effective date of reinstatement or the effective date of the coverage change applied for:

- (i) the condition of my health, the amount of my income, and the status of my employment or occupation are the same as given in the application; and
- (ii) I, the proposed insured, have not received any medical advice or treatment from a physician or other medical practitioner since the date of this application.

If there are any exceptions to (i) or (ii) above, the reinstatement or coverage change will not go into effect and I will immediately give MetLife details in writing

The effective date of the reinstatement will be the later of: (a) the date MetLife approves this application; and (b) the date on which MetLife receives all past due premiums. Past due premiums may only be paid to MetLife after it approves this application. If this is an application for a coverage change, then the coverage change will take effect on the effective date of the change.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Witness (Licensed Resident Agent)	Place (City/State)	Month/Day/Year	Signature of Proposed Insured
			X



AUTHORIZATION

In connection with an application for insurance, for underwriting and claim purposes, I authorize:

- Any medical practitioner or facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; group policyholder, contract holder, or any benefit plan administrator to give Metropolitan Life Insurance Company (the "Company"), or any third party acting on behalf of the Company in this regard:
 - personal information and data about me;
 - medical information, records and data, about me, including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about me related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data about me relating to mental illness, other than psychotherapy notes.
- The Company to redisclose information, records, and data received pursuant to this Authorization about me as authorized by me in writing or as otherwise permitted by applicable law.
- The Company, or any third party acting on behalf of the Company in this regard, to request and obtain consumer, investigative consumer or motor vehicle reports about me.
- Any employer, business associate, financial institution, or government agency to give the Company, or any third party acting on behalf of the Company in this regard, any information or data that it may have about my occupation, avocations, driving record, finances, character, reputation and aviation activities.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that the Company receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company, 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 the Company, may no longer be covered by those laws or regulations.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- I may ask to be interviewed if an investigative consumer report is ordered. Please call me at () _____, time _____ if such report is ordered.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- This authorization will end 30 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company at _____ and advising the Company that I have revoked this Authorization. Revocation may result in rejection of the application or in denial of coverage or a claim for benefits. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

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

Signature of Proposed Insured: _____ Date: _____

Print Name of Proposed Insured: _____





Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

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

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

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

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company
General American Life Insurance Company
SafeGuard Life Insurance Company**

**MetLife Insurance Company of Connecticut
SafeGuard Health Plans Inc.**

Compensation Disclosure Notice - New York

MetLife and its affiliated insurance companies and broker-dealers are committed to helping you select an appropriate product based on your financial needs and stated investment objectives.

Your MetLife sales representative ("Representative") is an employee of a MetLife Company, or associated with MetLife's New England Financial® distribution channel.

Your Representative is authorized to offer and sell products to you that are either issued or distributed by Metropolitan Life Insurance Company or certain of MetLife's affiliated insurance companies, or offered through one of MetLife's affiliated entities that is registered as a broker-dealer with whom you have an account relationship (each, a "MetLife Company" and, together, the "MetLife Companies").* Products from the MetLife Companies include fixed life insurance and annuities, property, casualty, and health insurance, variable annuities, and variable life insurance ("MetLife Products"). Your Representative also may be authorized to offer you certain products, including insurance, annuities, and mutual funds, issued by companies other than the MetLife Companies ("non-MetLife products").

Your Representative acts on behalf of the MetLife Companies in connection with the offer and sale of MetLife Products to you. He or she acts on behalf of a company other than MetLife in connection with the sale of non-MetLife products. Your Representative also may service your mutual funds, securities or insurance products on behalf of the company issuing the product.

Your Representative is compensated by a MetLife Company for sale, renewal and servicing of MetLife Products and certain authorized non-MetLife products. This compensation includes base commissions and other forms of compensation that may vary from product to product and by the amount of the purchase payment made by you. You should be aware that the amount of his or her compensation may increase in part based upon the relative amount of MetLife Products and certain non-MetLife products that he or she sells during a set period. He or she also is eligible for additional cash compensation (such as medical, retirement and other benefits) and non-cash compensation (such as conferences and sales support services) based on his or her sales of MetLife Products, certain authorized non-MetLife products, and overall sales and productivity. Your Representative may also receive compensation for the sale, renewal and servicing of authorized non-MetLife products directly from the issuing company. In some instances, MetLife Companies may also pay for expenses incurred by Representatives in connection with events for clients and prospects, training and education opportunities, and other miscellaneous expenses. MetLife receives compensation for non-MetLife Products sold by your Representative. This compensation will vary based upon an agreement between a MetLife Company and the issuing company and may include a bonus feature or a marketing allowance, which may be used in some

instances to offset expenses associated with conducting due diligence on the company and its products, and hosting training and education, or recognition, conferences. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information from your Representative, independent broker or independent agent about the compensation he or she expects to receive as a result of the sale of a MetLife Product or non-MetLife product.

Additionally, sales management is compensated for MetLife Products and approved non-MetLife Products that are sold by your Representative through MetLife. Generally, this compensation is aligned with that of your Representative, as noted above.

The services provided by your Representative may include:

- Discussing your current financial condition, goals and objectives;
- Gathering relevant financial information;
- Analyzing your financial situation (including among other things your needs, goals, risk tolerance, investment experience and time horizon) in order to determine appropriate strategies and recommendations of suitable investment or insurance products;
- Making recommendations regarding asset allocation;
- Making recommendations involving investment repositioning;
- Implementing these recommendations; and
- Reviewing your progress against your financial goals and objectives.

These services are **not** investment advisory or financial planning services subject to the Investment Advisors Act of 1940. If you are interested in such services, ask your Representative. Either your Representative or another MetLife or New England Financial Representative may be able to provide investment advisory or financial planning services. Before receiving those services, however, you will be provided with an additional disclosure and enter into a separate written agreement regarding those services as required by the Investment Advisors Act of 1940.

In addition to your Representative, certain independent brokers and agents sell products through an association with a MetLife or New England Financial sales office. They are compensated by a MetLife Company for the sale, renewal and servicing of MetLife Products. Those brokers and agents may receive increased compensation based upon the amount of MetLife Products sold during a set period. If you purchased your MetLife Product through the MetLife Auto & Home Group Insurance Program we may also pay an agent or broker representing the employer/organization participating in the Group Insurance Program for the sale and renewal of MetLife Products. We may also pay your employer or association or a third party acting on their or our behalf for the administration and service they provide related to the Group Insurance Program. Administration and services may include payroll administration.

* The following are the MetLife Companies whose products your Representative may be authorized to sell: Metropolitan Life Insurance Company, Metropolitan Property and Casualty Insurance Company, Metropolitan Casualty Insurance Company, Metropolitan General Insurance Company, Metropolitan Direct Property and Casualty Insurance Company, Metropolitan Group Property and Casualty Insurance Company, Metropolitan Lloyds Insurance Company of Texas, Economy Fire & Casualty Company, Economy Preferred Insurance Company, Economy Premier Assurance Company, First MetLife Investors Insurance Company, MetLife Investors USA Insurance Company, MetLife Investors Insurance Company, MetLife Insurance Company of Connecticut, New England Life Insurance Company, General American Life Insurance Company, MetLife Securities, Inc., Walnut Street Securities, Inc., New England Securities Corporation and Tower Square Securities, Inc. For more information, please refer to www.metlife.com.

"New England Financial" is a registered service mark of New England Life Insurance Company.

**ADG AND MLR SALES REPRESENTATIVES:
THIS IS IMPORTANT INFORMATION REGARDING YOUR COMPENSATION DISCLOSURE:**

- ✓ You must leave the Compensation Disclosure Notice with your client.
- ✓ You must confirm delivery by signing this document below and returning it with application.

Sales Representative Compensation Disclosure Report

- I have delivered the Compensation Disclosure Notice to the applicant(s).

[Required for business sold by ADG (MetLife and NEF) and MLR sales representatives].

Signature of Licensed & Appointed
Sales Representative

Name of Licensed & Appointed
Sales Representative

ADG and MLR Sales Representative Instruction: You must forward this form with any application submitted for timely processing.

Individual Disability Income Insurance Policy

Application Process: What's Next?

Thank you for choosing MetLife for your insurance needs. Upon receiving your application materials, we will begin reviewing your application and processing your information. Here is an overview of what you can expect during the underwriting process of your disability application:

Personal History Telephone Interview

- A MetLife associate may call you within ten days to discuss your application.
- The interview should take no more than 15 minutes.
- The associate will ask you questions regarding your medical history, occupational duties, and financial information.
- If you receive a call from a MetLife associate and you are unavailable, a message will be left requesting you to call (888)838-3444 between 9:00 AM and 7:00 PM EST. Returning this call will help expedite your application processing.

Request for Financial Documentation

As our disability income policy provides insurance for replacing your income, we may ask you to provide us with proof of your income. This may include:

- Most recent and prior year W-2 statements
- A copy of your most recently filed Federal Income Tax Return Form 1040 with all supporting schedules
- Copies of business tax returns with all supporting schedules

Paramedical Exam

If an examination is required, a representative from one of our paramedical services will call you to schedule an examination at a time convenient for you. The representative will advise you of any special instructions if you are required to fast prior to your examination. At the examination, the technician will:

- Draw blood
- Check your blood pressure and weight
- Collect a urine sample
- Ask medical questions

Should you have any additional questions about our underwriting process, please speak with your agent/producer. We thank you for your business, and look forward to speaking with you!

Agent/Producer Name: _____

Telephone number: _____

Agent/Producer Email Address: _____

(Or attach Agent/Producer's business card here! →)

