For use in the state of:
Pennsylvania

MetLife®

Individual Long-Term Care Insurance (LTCI) Application Packet for MetLife's Multi-Life Program

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MetLife LTC LifeStage Advantage℠

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

IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

Complete this application for Multi-Life program applicants only. Individual applicants require a different application.

Complete required forms in Client Packet and leave with applicant.

Please note that if the employee answers **YES** to any question in Part C, you should call the Underwriting Pre-screen Line at (888) 799-0906 to verify if the application process should continue.

If split billing is used and Core Buy-up method was selected during group setup, select the options for complete coverage desired.

For split billing, complete preference(s) for the employee only. The employer billing was established when the group was approved.

SIMPLIFIED UNDERWRITING

Available only to Employer Multi-Life groups that have been pre-approved for Simplified Underwriting.

Employees allowed to use the Simplified Underwriting section of the application are:

- W-2 Employees who are actively at work and working a minimum of 30 hours per week
- Those age 65 or younger
- Those not requesting benefits in excess of $9K Monthly Benefit Amount or $500K Total Benefit Amount

Spouses/Domestic Partners (age 65 or younger) of employees are permitted to use Simplified Underwriting only if premiums, for the Spouse/Domestic Partner, are paid by the employer and they are part of a 10+ group.

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.

Note: For those selecting list bill/payroll deduction, premium payments will not be accepted with this application.

MODIFIED UNDERWRITING

Available to all eligibles who do not qualify for Simplified Underwriting.

All applicants between the ages of 66 - 69, inclusive, will require a phone health interview. The call is initiated by a Nurse representing MetLife. The interview lasts approximately 20 - 30 minutes, inclusive, 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 66 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.

Note: For those selecting list bill/payroll deduction, premium payments will not be accepted with this application.

APPLICATION PACKET SUBMISSION CHECKLIST

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

- ❑ Multi-Life Program Group Number in Part A.
- ❑ All Health Information is complete (pages 3-5).
- ❑ For Automatic Checking Account Deduction of premium, include a voided check and complete and sign Part F, Question 2 (page 6)
- ❑ The Medical Authorization is signed by the applicant (page 9).
- ❑ The Personal Worksheet is completed (pages 12-13).
  If the applicant chooses not to complete the Personal Worksheet, please complete the Authorization to Proceed Processing Application Form (page 14).
- ❑ Correct distribution channel is selected and all information is completed accurately in Agent/Producer's Report (pages 16-17).
- ❑ 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

Individual Long-Term Care Insurance (LTCI) Application for MetLife's Multi-Life Program

Metropolitan Life Insurance Company, ("MetLife") • New York, NY A complete copy of this application consists of Parts A-G.

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

PART A PERSON APPLYING FOR COVERAGE (You must complete ALL information below.)

Multi-Life Program Group #: _____ **Multi-Life Program Group Name** _____

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. Social Security Number _____
9. Marital Status
   ❑ Single/Widowed/Divorced
   ❑ Married
   ❑ Domestic Partner*
10. Relationship to Employee/Member:
    ❑ Self ❑ Retiree
    ❑ Spouse/Domestic Partner* ❑ Parent (includes in-laws)
    ❑ Adult Child ❑ Grandparent (includes in-laws)
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. Are you eligible for and applying for Simplified Underwriting?
    ❑ **YES** ❑ **NO**
13. Are premiums being paid by Employer? ❑ **YES** ❑ **NO**
    IF YES is Employee or Spouse/Domestic Partner eligible for split billing? ❑ **YES** ❑ **NO**

If you are the Employee/Member:

14. Name of your Employer: _____
15. Date of Hire: _____ (mm/dd/yyyy)
    Title/Position _____
16. Employee I.D. (if applicable) _____
17. Are you actively at work** 30 hours per week or more?
    ❑ **YES** ❑ **NO**
18. **If you are NOT the Employee/Member,** please provide the Employee/Member's:
    Name _____
    Social Security Number _____
19. This is a request for ❑ Initial Coverage ❑ Re-apply

*"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.

**Actively at Work means that you are working at your usual place of employment, or other location to which your employer requires you to travel, and are performing all of the usual and customary duties of your occupation on a regular full-time basis, on the date this application is signed.

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 Limited Guaranteed Purchase Option Rider.
(For Simplified Underwriting, selection can not exceed $300K.)

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

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

❑ 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)
(For Simplified Underwriting, selection can not exceed $9K Monthly Benefit Amount or $500K Total Benefit Amount.)

MONTHLY BENEFIT AMOUNT	TOTAL 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:

❑ 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)

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

PART C INSURABILITY QUESTIONS

SIMPLIFIED UNDERWRITING – Answer questions in Parts C, skip Part D (not applicable to Simplified Underwriting) and continue to Part E.
MODIFIED UNDERWRITING – Answer questions in all sections.

1. Have you been medically advised as having or have you been medically treated for:

YES	NO		YES	NO
❑	❑	Stroke (CVA)	❑	❑
❑	❑	Multiple Transient Ischemic Attacks (TIA's)	❑	❑
❑	❑	TIA **within the past 5 years**	❑	❑
❑	❑	Alzheimer's disease	❑	❑
❑	❑	Dementia/Organic brain syndrome	❑	❑
❑	❑	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	❑	❑
❑	❑	Mental retardation	❑	❑
❑	❑	Schizophrenia	❑	❑

	YES	NO
Amyotrophic lateral sclerosis (ALS)	❑	❑
Muscular dystrophy	❑	❑
Multiple sclerosis	❑	❑
Parkinson's disease	❑	❑
Huntington's chorea	❑	❑
Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated **in the past 12 months** (except basal cell, squamous cell cancer of the skin)	❑	❑
Diabetes combined with kidney disease, circulatory disease, heart disease, TIA, or any type of diabetic complication(s)	❑	❑
Organ transplant	❑	❑

2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	❑	❑
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 by a member of the medical profession to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?	❑	❑
5. Do you currently reside in, or have you been advised by a member of the medical profession 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?	❑	❑

SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY

Complete this section if: You are part of a Simplified Underwriting group, you are under age 65, and your Spouse or Domestic Partner's employer is paying the premium.

6. 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? ❑ ❑

IF YES please explain: _____

This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.

PART D HEALTH QUESTIONS (Provide additional information in the DETAILS section on page 5.)

SKIP PART D IF SIMPLIFIED UNDERWRITING

Primary Care Physician (with most of your records)

Physician _____ Phone Number ( ) _____ Date Last Seen _____

Address _____ City _____ State _____ Zip _____

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

Physician _____ Phone Number ( ) _____ Date Last Seen _____

Address _____ City _____ State _____ Zip _____

Physician _____ Phone Number ( ) _____ Date Last Seen _____

Address _____ City _____ State _____ Zip _____

PART D HEALTH QUESTIONS – *continued* (Provide additional information in the DETAILS section on page 5.)

Underwriting requirements: Applicants ages 66-69, 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.

YES **NO**

1. Have you been medically advised as having or have you been medically treated for:
   If YES check applicable condition(s). ❑ ❑

Cancer (excluding basal cell of skin)	❑	Disorders of the brain/spinal cord	❑
Heart disease/circulatory conditions/ hypertension	❑	Psychiatric condition(s)/mood disorders/ depression/anxiety	❑
Transient Ischemic Attack (TIA)	❑	Arthritis/joint replacement/fractured hip	❑
Chronic lung disease/ chronic obstructive pulmonary disease (COPD)/emphysema	❑	Connective tissue condition(s)/lupus/ scleroderma/CREST	❑
Chronic kidney disease	❑	Osteoporosis	❑
Chronic liver disease/hepatitis	❑	Tremor/gait disturbance	❑
Diabetes	❑	Muscle/back disorders	❑
Neurological condition(s)	❑	Memory loss/forgetfulness	❑

2. Do you have any other medical condition(s), planned surgery or medical testing, or any condition(s) for which you are seeking or plan to seek medical advice? ❑ ❑

3. Have you **ever** had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard? ❑ ❑

4. Are you receiving any disability payments or worker's compensation? ❑ ❑

5. Did you answer **YES** to any question 1-4? **IF YES** provide details below for **each YES** answer. ❑ ❑

Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)

6. Have you taken any medications (excluding vitamins) or supplements **in the past 12 months?**
   If YES provide details below for **each** medication. ❑ ❑

Medication	Dosage/ Frequency	Reason For Taking	Name of Prescribing Health Professional

7. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) **in the past 2 years**?
   IF YES indicate date of last use. _____mm/dd/yyyy ❑ ❑

8. Do you consume alcoholic beverages?
   How often? _____ How much? _____ ❑ ❑

9. Have you **ever** been medically treated, hospitalized or counseled for the use of alcohol or controlled substances?
   IF YES indicate date of last treatment. _____mm/dd/yyyy ❑ ❑

10. What is your: height (in inches)? _____ weight (in pounds)?_____

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.

Dr. Info/Ques. #	Details

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

State regulations require that we ask the following questions if you are applying for insurance.	YES	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? _____	❑	❑
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? _____ If that policy or certificate lapsed, when did it lapse? _____ (mm/dd/yyyy) Is the policy in-force under a nonforfeiture benefit provision?	❑ ❑	❑ ❑
3. Are you covered under Medicaid? ("Medicaid" is different from "Medicare.") If you are eligible or covered by Medicaid, you may not need to purchase the policy since it may provide duplicate benefits.	❑	❑
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 8. Policy Number _____ Insurance Company Name _____ Insurance Company Address _____ _____	❑	❑

PART F PAYMENT SELECTIONS

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.

❑ Employer List Bill/Payroll Deduction

This option may only be selected if available through your employer, and then is only open to employees and their Spouses/Domestic Partners. Deduction will be made from the payroll of the employee. Employee must sign this authorization even if application is for Spouse/Domestic Partner.

Authorization: I authorize the required premium for the coverage level selected to be deducted from my pay.

X _____ _____
Signature of Employee for Employer List Bill/Payroll Deduction Authorization (if premiums are payroll deducted) Date

❑ Annual Direct Bill ❑ Semi-Annual 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.

Name _____ Phone Number ( ) _____

Address _____

City _____ State _____ Zip _____

❑ 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 voided blank check 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.

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.

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 Date

ATTACH VOIDED CHECK HERE
DO NOT send deposit slips.

PART G AGREEMENT AND ACKNOWLEDGEMENT

Required Information. Please check to indicate that you have received all of the following items:

- ❑ Privacy Notice
- ❑ Long-Term Care Insurance Potential Rate Increase 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.

❑ **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 _____ Phone Number ( ) _____

Address _____

City _____ State _____ Zip _____

Relationship _____

❑ **Rejection of 5% Automatic Compound Inflation Protection Rider** (if applicable)
I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of this 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 _____ _____
Signature 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.

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*

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.

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 or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

X _____ _____ _____

Signature of Applicant | Date | Signed at City, State

X _____ _____ _____

Signature of Licensed and Appointed Agent/Producer | Date | Signed at City, State

LTC4APP-ML-PA

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.
Metropolitan Life Insurance Company ("MetLife"), New York, NY
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 _____ **X** _____

Signature of Licensed and Appointed Agent/Producer | Signature of Applicant | Date

_____

Print Name of Licensed and Appointed Agent/Producer

_____

Address of Licensed and Appointed Agent/Producer

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 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.
- 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 | Date of Birth

X _____ _____

Signature of Applicant | Date

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, Wesport, 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 Date

_____
Print Name of Applicant

_____
Address

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 | Signature of Applicant | Date

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 Pennsylvania 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

Select Policy Form Number: LTC2007-ML-PA 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):

❑ $ _____ 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 Form	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)

❑ 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%?

❑ Yes ❑ No

What is your annual income? (check one)

❑ 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)

❑ 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)

❑ 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?

❑ 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?

Number of days 100 $ _____ Approximate cost for that period of care

---

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

❑ 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)

❑ 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)

❑ 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 other options for financing your long-term care.

DISCLOSURE STATEMENT

(You 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 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 _____ _____

Signature of Applicant 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 Date

CONDITIONAL PREMIUM RECEIPT

EMPLOYER LIST BILL/PAYROLL DEDUCTION PARTICIPANTS ARE NOT ELIGIBLE FOR CONDITIONAL PREMIUM RECEIPT.

Received from _____
Name of Applicant (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 returnedto 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 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

Jeffrey A. Welikson

Jeffrey A. Welikson, 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.**

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

	YES	NO
1. Did you personally interview the Applicant face to face and witness his or her signature? **IF "NO"** give details: _____ _____	❑	❑
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: _____ _____	❑	❑
3. Is special consideration needed for (check all that apply): ❑ Hearing Impairment ❑ Language Translation Please explain: _____ _____		
4. Please list other health insurance policies sold by you to the Applicant that are still in-force: _____ _____		
5. List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force: _____ _____		
6. Did the Agent/Producer/Agency order the APS? **IF YES** include a copy of the order form. Physician Name: _____ Vendor _____ Date Ordered: _____ (mm/dd/yyyy)	❑	❑
7. Is this a replacement policy? (**IF YES** complete the Replacement Notice on page 8.)	❑	❑
8. 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): ❑ Standard ❑ Preferred (not available with Simplified Underwriting)		
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 by me and that I have accurately recorded the information supplied by the Applicant. The Applicant 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 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. I certify that any required written disclosure statement was given to the Applicant no later than the date this application was signed.

Print Name of Licensed & Appointed Agent/Producer or Enroller _____ Signature of Licensed & Appointed Agent/Producer or Enroller _____

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.

MetLife®

Metropolitan Life Insurance Company
New York, NY

order #:
LTC4APP-ML-PA (0310)