ENROLLMENT FORM
AlumniTerm 10/20

The Alumni Insurance Program®

MetLife
Metropolitan Life Insurance Company New York, NY 10166

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:	Group Customer #	CLI #	Campaign Code #

Sponsoring College, University, School, or Alumni/ae Association (If different than the Policyholder):

YOUR ENROLLMENT INFORMATION

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
	– –	
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Email Address	Phone #	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.
I understand that contributions are required for the benefits I select below.

Term Life[1] Insurance for Alumnus

Select an amount: ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $1,000,000 ☐ $1,500,000 ☐ Other (Enter a multiple of $25,000 with a minimum of $100,000 and up to a maximum of $3,000,000.) $_____ **Select a Term:** ☐ 10 Year (age 69 or less) ☐ 20 Year (age 59 or less)

Term Life[1,3] Insurance for Spouse/Colorado Statutory Designated Beneficiary/Domestic Partner [2] (Spouse/CSDB/DP)

(Applicable when Spouse/CSDB/DP is not an Alumnus)

Select an amount: ☐ $100,000 ☐ $250,000 ☐ $500,000 ☐ $1,000,000 ☐ $1,500,000 ☐ Other (Enter a multiple of $25,000 with a minimum of $100,000 and up to a maximum of $3,000,000.) $_____ **Select a Term:** ☐ 10 Year (age 69 or less) ☐ 20 Year (age 59 or less)

Smoking Status Information for Term Life Insurance

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year? **Alumnus:** ☐ Yes ☐ No **Spouse/CSDB/DP:** ☐ Yes ☐ No

Term Life[3] Insurance for Child(ren) ☐ $10,000

Dependent Information: If you are applying for coverage for your Spouse/CSDB/DP and/or Child(ren), please provide the information requested below.

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper, sign, date it and return it with your enrollment form.

Name of your Spouse/CSDB/DP (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you?

Alumnus: ☐ Yes ☐ No. If Yes, provide Name of Company_____ Policy Number: _____

Spouse/CSDB/DP: ☐ Yes ☐ No. If Yes, provide Name of Company_____ Policy Number: _____

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper, sign, date it and return it with your enrollment form.

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor. [2] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest. [3] Amounts will be subject to state limits, if applicable.

GEF02-1-CO
ADM
(The form number at left applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. For questions 5, 9, 10, and 11, for "yes" answers, please provide full details in Section 2.

	Alumnus	Spouse/CSDB/DP (Non Alumnus)
1. Your height ____ feet ____ inches Your weight: ____ pounds Spouse/CSDB/DP height: ____ feet ____ inches Spouse/CSDB/DP weight ____ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? ..... ☐ Yes ☐ No Indicate type of diet:	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you now pregnant? ..... ☐ Yes ☐ No If "yes," what is your due date (month/day/year)?____/____/____ Physician's name: _____ Physician's Telephone: (____) ____ – ____	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you now, or have you in the past 2 years, used tobacco in any form? ..... ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? .... ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? ..... ☐ Yes ☐ No If "yes", specify "date(s) of conviction(s)(month/day/year) ____ / ____ / ____	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? ..... ☐ Yes ☐ No ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified ☐ issued other than as applied for? If "yes", indicate reason:	☐ Yes ☐ No	☐ Yes ☐ No

GEF09-1
HEA
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GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

HEALTH INFORMATION SECTION 1 (continued)

	Alumnus	Spouse/CSDB/DP (Non Alumnus)
8. Are you now receiving or applying for any disability benefits, including workers' compensation? If "yes", please provide details:	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐ Yes ☐ No	☐ Yes ☐ No
10. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No	☐ Yes ☐ No
For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: cardiac or cardiovascular disorder; stroke or circulatory disorder; high blood pressure; cancer, Hodgkins disease, lymphoma or tumors; anemia, leukemia or other blood disorder; diabetes; asthma, COPD, emphysema or other lung disease; ulcers, stomach, hepatitis or other liver disorder; colitis, Crohn's, diverticulitis or other intestinal disorder; memory loss; epilepsy, paralysis, seizures, dizziness or other neurological disorder; Epstein-Barr, chronic fatigue syndrome or fibromyalgia; multiple sclerosis, ALS or muscular dystrophy; lupus, scleroderma, auto immune disease or connective tissue disorder; arthritis; back, neck, knee, spinal, joint or other musculoskeletal disorder; carpal tunnel syndrome; kidney, urinary tract or prostate disorder; thyroid or other gland disorder; mental, anxiety, depression, attempted suicide or nervous disorder; sleep apnea?	☐ Yes ☐ No	☐ Yes ☐ No

After completing the Personal Physician and Prescription Information, please provide full details for "yes" answers to questions 5, 9, 10, and 11 in Section 2.

If you need more space, attach a separate sheet. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

Personal Physician Information for Alumnus

☐ Check here if you are attaching another sheet. Please remember to sign and date it.

Personal Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

Date of last visit (MM/DD/YYYY): / /

Reason for visit:

Prescription Information: Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication:

Condition/Diagnosis:

Prescribing Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

Personal Physician for Spouse/CSDB/DP (Non-Alumnus)

☐ Check here if you are attaching another sheet. Please remember to sign and date it.

Personal Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

Date of last visit (MM/DD/YYYY): / /

Reason for visit:

Prescription Information: Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication:

Condition/Diagnosis:

Prescribing Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

HEALTH INFORMATION SECTION 2

Please provide full details below for each "Yes" answer to questions 5, 9, 10, and 11 in Section 1.

If you need more space to provide full details, attach a separate sheet. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

☐ Check here if you are attaching another sheet. Please remember to sign and date it.

Health Information for Alumnus

Question Number:

Condition/ Diagnosis/Type:

Please list any medication prescribed that you did not already identify in the Prescription Information above:

Date of Diagnosis: (Month/Year) /

Date of Last Treatment: (Month/Year) /

Type of Treatment:

Treating Health Professional

Personal Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

Date of last visit (MM/DD/YYYY): / /

Reason for visit:

☐ Check here if you are attaching another sheet. Please remember to sign and date it.

Health Information for Spouse/CSDB/DP (Non-Alumnus)

Question Number:

Condition/ Diagnosis/Type:

Please list any medication prescribed that you did not already identify in the Prescription Information above:

Date of Diagnosis: (Month/Year) /

Date of Last Treatment: (Month/Year) /

Type of Treatment:

Treating Health Professional

Personal Physician's Name:

Telephone: ( ) –

Address:

City, State, Zip Code:

Date of last visit (MM/DD/YYYY): / /

Reason for visit:

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued. **Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law. **Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. **Kentucky:** 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. **Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties. **New York** (only applies to Accident and Health Insurance): 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 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. **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law. **Pennsylvania and all other states:** 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.

GEF09-1
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BENEFICIARY DESIGNATION

I designate the following person as primary beneficiary for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

☐ Check here if multiple beneficiaries or a Trust is preferred and we will send you the appropriate information.

Beneficiary of Applicant

Full Name (First, Middle, Last)

Social Security # - - Date of Birth (Mo./Day/Yr.) / /

Relationship Phone # ( ) -

Address

City, State, Zip

Beneficiary of Spouse/CSDB/DP

Full Name (First, Middle, Last)

Social Security # - - Date of Birth (Mo./Day/Yr.) / /

Relationship Phone # ( ) -

Address

City, State, Zip

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge: 1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability. 2. I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities. 3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. 4. If I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase. 5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose. 6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Applicant | Print Name | Date Signed (MM/DD/YYYY)

Signature of Spouse/CSDB/DP | Print Name | Date Signed (MM/DD/YYYY)

GEF09-1
DEC
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GEF09-1
DEC *applies to residents of Connecticut, North Dakota and Utah)*

Some services in connection with your coverage may be performed by our affiliate, MetLife Services and Solutions, LLC. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

PAYMENT INFORMATION I am selecting the following payment options (check the boxes below):

Method of Payment: ☐ Paper Bill ☐ Easy Pay Authorization*

Frequency of payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (Easy Pay Authorization required for Monthly payment option)

*An Easy Pay Authorization Form will be sent to you for payments from your designated bank account or credit card.

After signing this Declarations and Signature page, please be sure to sign the enclosed Authorization form that follows this page.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:

- personal information and data about the proposed insured including employment and occupational information;

  medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
- information, records and data about the proposed insured 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 the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
- motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her 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 to 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.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Signature of Alumnus | Date Signed (MM/DD/YYYY)

Print Name | State of Birth | Country of Birth

Signature of Spouse/Colorado Statutory Designated Beneficiary/Domestic Partner | Date Signed (MM/DD/YYYY)

Print Name | State of Birth | Country of Birth