For use in the state of:

Oregon

MetLife®

Individual Long-Term Care Insurance (LTCI) Application Packet

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VIP2

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

IMPORTANT INSTRUCTIONS FOR AGENTS/PRODUCERS

Complete this application for individual applicants only.

Multi-Life program applicants must use the Multi-Life application.

Complete required forms in Client Packet and leave with applicant.

All applicants between the ages of 56 - 69, inclusive, will require a phone health interview. The call is initiated by a Nurse representing MetLife. The interview lasts approximately 20 - 30 minutes, depending on health history. To save time during the interview, please ask your client to have the following available:

- Current medication bottles
- Names, addresses and phone numbers of physicians
- Dates of any surgeries or hospitalizations

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

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

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

The Beneficiary Designation Form should only be completed if the applicant is selecting the Return of Premium Rider and chooses to designate a beneficiary other than their estate.

If you are collecting premium payment at time of application, full modal premium is recommended, but no less than one month's premium should be collected unless your state does not permit it.

APPLICATION PACKET SUBMISSION CHECKLIST

To avoid a delay in processing, confirm the following:

- ❑ Name of Applicants **A** and **B** are at the top of **each** page.
- ❑ All Health Information is complete (pages 3-6).
- ❑ For Automatic Checking Account Deduction of premium, include a voided check and complete and sign Part F, Question 2 (page 7).
- ❑ The Medical Authorization is signed by the applicant(s) (pages 10-11).
- ❑ The Personal Worksheet is completed (pages 16-17).
  If the applicant chooses not to complete the Personal Worksheet, please complete the Authorization to Proceed Processing Application Form (page 18).
- ❑ Correct distribution channel is selected and all information is completed accurately in Agent/Producer's Report (pages 20 -21).
- ❑ All appropriate licensing, appointments, LTC CE's and/or Partnership certifications (if applicable) have been completed prior to submission of the application.
- ❑ 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

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

APPLICANT A

E New Business Policy # _____ (ADG only)

1. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. (check one)
2. First Name _____ Middle Initial ___
   Last Name _____
3. Address _____
   City _____ State _____ Zip _____
4. Preferred Contact Phone Number ( ) _____
   Additional Phone Number ( ) _____
   Best time to call ❑ Morning ❑ Afternoon ❑ Evening
5. E-mail address _____
6. Gender ❑ Male ❑ Female
7. Date of Birth _____ (mm/dd/yyyy)
   Place of Birth _____ (State & Country)
8. Height _____ Weight _____
9. Social Security Number _____
10. Marital Status ❑ Single/Widowed/Divorced
    ❑ Married
    ❑ Domestic Partner*
11. Is your Spouse or 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 or Domestic Partner* ❑ Household Member
    Name _____
    Social Security Number _____
12. This is a request for ❑ New Coverage
    ❑ Increase of Existing Coverage
    ❑ Exercise Life or DI GPO Rider

APPLICANT B

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

1. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. (check one)
2. First Name _____ Middle Initial ___
   Last Name _____
3. Address _____
   City _____ State _____ Zip _____
4. Preferred Contact Phone Number ( ) _____
   Additional Phone Number ( ) _____
   Best time to call ❑ Morning ❑ Afternoon ❑ Evening
5. E-mail address _____
6. Gender ❑ Male ❑ Female
7. Date of Birth _____ (mm/dd/yyyy)
   Place of Birth _____ (State & Country)
8. Height _____ Weight _____
9. Social Security Number _____
10. Marital Status ❑ Single/Widowed/Divorced
    ❑ Married
    ❑ Domestic Partner*
11. Is your Spouse or 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 or Domestic Partner* ❑ Household Member
    Name _____
    Social Security Number _____
12. This is a request for ❑ New Coverage
    ❑ Increase of Existing Coverage
    ❑ Exercise Life or DI GPO Rider

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

_____ **APPLICANT A** **APPLICANT B** _____

PART B COVERAGE SELECTIONS

1 – Select Your Plan of Coverage:

APPLICANT A

❑ Value ❑ Ideal ❑ Facilities-Only

APPLICANT B

❑ Value ❑ Ideal ❑ Facilities-Only

2 – Select Your Maximum Nursing Home Daily Benefit Amount ("DBA"):

APPLICANT A

DBA: $ _____ ($50 to $400 per day in $10 increments)

APPLICANT B

DBA: $ _____ ($50 to $400 per day in $10 increments)

3 – Select Your Benefit Period Multiplier: (Your **Total Lifetime Benefit** = Benefit Period x DBA)

APPLICANT A

❑ 730 (2-year) ❑ 1,095 (3-year) ❑ 1,460 (4-year)
❑ 1,825 (5-year) ❑ 2,555 (7-year)

APPLICANT B

❑ 730 (2-year) ❑ 1,095 (3-year) ❑ 1,460 (4-year)
❑ 1,825 (5-year) ❑ 2,555 (7-year)

4 – Select Your Home/Community-Based Care Benefit %*: (Do not select any if you chose Facilities Only.)

APPLICANT A

❑ 100% ❑ 75% ❑ 50%

APPLICANT B

❑ 100% ❑ 75% ❑ 50%

* **For Value:** Home Care and Assisted Living Facility Care paid at this percentage of the DBA.
***For Ideal:** Home Care paid at this percentage of the DBA.

5 – Select an Elimination Period:

APPLICANT A

❑ 20 Days ❑ 45 Days ❑ 100 Days

APPLICANT B

❑ 20 Days ❑ 45 Days ❑ 100 Days

6 – Select Optional Riders:

APPLICANT A

Choose ONE Enhanced Elimination Period Option if desired.

❑ Calendar Day Rider (Not available with Facilities Only)
❑ Home Care EP Waiver (Not available with Facilities Only)

Choose Benefit Riders as desired.

❑ Shared Care (Not available with Restoration of Benefits Rider. Spouse or Domestic Partner must have identical coverage.)
❑ Indemnity (Only available with Value Policy)
❑ Restoration of Benefits (Not available with Shared Care Rider)
❑ Paid-Up Survivorship
❑ Return of Premium – To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.

APPLICANT B

Choose ONE Enhanced Elimination Period Option if desired.

❑ Calendar Day Rider (Not available with Facilities Only)
❑ Home Care EP Waiver (Not available with Facilities Only)

Choose Benefit Riders as desired.

❑ Shared Care (Not available with Restoration of Benefits Rider. Spouse or Domestic Partner must have identical coverage.)
❑ Indemnity (Only available with Value Policy)
❑ Restoration of Benefits (Not available with Shared Care Rider)
❑ Paid-Up Survivorship
❑ Return of Premium – To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.

7 – Benefit Increase Options (Choose one)

APPLICANT A

❑ Future Purchase Rider*
❑ 5% Automatic Simple Inflation Protection Rider
❑ 5% Automatic Compound Inflation Protection Rider
❑ I DO NOT choose Inflation Protection

APPLICANT B

❑ Future Purchase Rider*
❑ 5% Automatic Simple Inflation Protection Rider
❑ 5% Automatic Compound Inflation Protection Rider
❑ I DO NOT choose Inflation Protection

* Not available if an Accelerated Premium Payment Rider is selected.

8 – Nonforfeiture Coverage Rider:

APPLICANT A

❑ **YES** ❑ **NO** I select Nonforfeiture Coverage Rider

APPLICANT B

❑ **YES** ❑ **NO** I select Nonforfeiture Coverage Rider

_____ **APPLICANT A** **APPLICANT B** _____

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

APPLICANT A YES	APPLICANT A NO	If you have any doubt about your answers, ask your doctor.	APPLICANT B YES	APPLICANT B NO
❑	❑	1. **Within the last 10 years**, have you had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke **within the past 5 years**, multiple strokes, stroke with residual impairment, Transient Ischemic Attack (TIA) **within the past 2 years**, multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	❑	❑
❑	❑	2. **Within the last 10 years**, 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 to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	❑	❑
❑	❑	5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	❑	❑

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

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

Primary Care Physician (with most of your records)

APPLICANT A

Physician _____

Address _____

City_____ State ____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

APPLICANT B

Physician _____

Address _____

City_____ State_____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

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

Physician _____

Address _____

City_____ State ____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

Physician _____

Address _____

City_____ State ____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

Physician _____

Address _____

City_____ State ____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

Physician _____

Address _____

City_____ State ____ Zip_____

Phone Number ( ) _____ Date Last Seen _____

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

You are required to answer all the questions in this section. Missing information will result in underwriting delays.
If you have any doubt about your answers, ask your doctor.

Underwriting requirements: Applicants ages 56-69, inclusive, will have a phone health interview. Applicants ages 70-84, inclusive, will require a face-to-face interview in their place of residence. Additionally, we may conduct a phone or face-to-face health interview regardless of age, to clarify health status.

1. **Within the last 10 years**, have you had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO	APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	Cancer (excluding basal or squamous cell of the skin)	❑	❑	❑	❑	Organ transplant completed or medically advised	❑	❑
❑	❑	Heart disease / condition(s)	❑	❑	❑	❑	Arthritis	❑	❑
❑	❑	Atrial fibrillation	❑	❑	❑	❑	Connective tissue disorder	❑	❑
❑	❑	Heart attack / angina	❑	❑	❑	❑	Lupus / Scleroderma / CREST	❑	❑
❑	❑	Heart surgery / angioplasty	❑	❑	❑	❑	Osteoporosis	❑	❑
❑	❑	Cardiomyopathy	❑	❑	❑	❑	Joint replacement / fractures / falls	❑	❑
❑	❑	Congestive heart failure	❑	❑	❑	❑	Paralysis / amputation / weakness	❑	❑
❑	❑	Hypertension	❑	❑	❑	❑	Bladder / bowel incontinence	❑	❑
❑	❑	Stroke / TIA	❑	❑	❑	❑	Numbness of extremities	❑	❑
❑	❑	Respiratory / lung condition(s)	❑	❑	❑	❑	Dizziness / fainting	❑	❑
❑	❑	Kidney / bladder condition(s)	❑	❑	❑	❑	Muscle disorder(s)	❑	❑
❑	❑	Liver condition(s)	❑	❑	❑	❑	Fibromyalgia	❑	❑
❑	❑	Diabetes / Endocrine condition(s)	❑	❑	❑	❑	Chronic fatigue syndrome	❑	❑
❑	❑	Neurological condition(s)	❑	❑	❑	❑	Polymyalgia rheumatica	❑	❑
❑	❑	Seizures / brain condition(s) / head injury	❑	❑	❑	❑	Tremor / imbalance / gait disturbance	❑	❑
❑	❑	Spine / back condition(s)	❑	❑	❑	❑	Memory loss / forgetfulness	❑	❑
❑	❑	Psychiatric condition(s)	❑	❑	❑	❑	Ulcerative colitis / Crohn's	❑	❑
❑	❑	Depression / anxiety / bipolar	❑	❑	❑	❑	Blood disorder(s)	❑	❑
❑	❑	Blindness	❑	❑	❑	❑	Hepatitis/cirrhosis	❑	❑

❑	❑	2. **Within the last 10 years**, have you had any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?	❑	❑
❑	❑	3. **Within the past 12 months**, have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?	❑	❑
❑	❑	4. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?	❑	❑
❑	❑	5. **Within the last 10 years**, have you resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	❑	❑
❑	❑	6. **Within the last 10 years**, have you had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?	❑	❑
❑	❑	7. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?	❑	❑

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

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

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

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

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

APPLICANT A YES	APPLICANT A NO		APPLICANT B YES	APPLICANT B NO
❑	❑	10. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) **within the past 2 years**? **IF YES** indicate date of last use. **APPLICANT A**_____ mm/dd/yyyy | **APPLICANT B** _____ mm/dd/yyyy	❑	❑
❑	❑	11. Do you consume alcoholic beverages? **APPLICANT A** How often? _____ How much? _____ | **APPLICANT B** How often? _____ How much? _____	❑	❑
❑	❑	12. **Within the last 10 years**, have you been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? **IF YES** indicate date of last treatment. **APPLICANT A**_____ mm/dd/yyyy | **APPLICANT B** _____ mm/dd/yyyy	❑	❑
❑	❑	13. Have you had a weight gain or loss of 10 pounds or more **within the past 12 months**? **IF YES** please specify: **APPLICANT A** Pounds lost _____ Pounds gained_____ | **APPLICANT B** Pounds lost_____ Pounds gained_____	❑	❑
❑	❑	14. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? **IF YES**, please describe. **APPLICANT A** ❑ I am employed: Job/Title _____ Hours/ Week _____ ❑ I participate in other activities: _____ _____ Hours/ Week _____ | **APPLICANT B** ❑ I am employed: Job/Title _____ Hours/ Week _____ ❑ I participate in other activities: _____ _____ Hours/ Week _____	❑	❑

PART D HEALTH QUESTIONS – *continued*

DETAILS: Please use the section below if you need additional space to complete your answers in Part D, including any other Physician Specialists you have seen **within the past 5 years**. You may attach additional sheets of paper, if needed. Be sure to include your name and Social Security Number on all sheets. Information provided on additional sheets will become part of the application and will be considered by MetLife in determining your eligibility for insurance.

APPLICANT A Question #	Details	APPLICANT B Question #	Details

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

APPLICANT A YES	APPLICANT A NO	Please Note: You are responsible for canceling any existing coverage you may have. State regulations require that we ask the following questions if you are applying for insurance.	APPLICANT B YES	APPLICANT B NO
❑	❑	1. Do you have another long-term care insurance policy or certificate in-force (including a health care service contract or a health maintenance organization contract)? **IF YES** coverage types/amounts? **APPLICANT A** _____ **APPLICANT B** _____	❑	❑
❑	❑	2. Did you have another long-term care insurance policy or certificate in-force during the last twelve (12) months? **IF YES** with which insurance company? **APPLICANT A** _____ **APPLICANT B** _____ If that policy or certificate lapsed, when did it lapse? **APPLICANT A** _____ (mm/dd/yyyy) **APPLICANT B** _____ (mm/dd/yyyy)	❑	❑
❑	❑	Is the policy in-force under a nonforfeiture benefit provision?	❑	❑
❑	❑	3. Are you covered under Medicaid? ("Medicaid" is different from "Medicare.")	❑	❑
❑	❑	4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? **IF YES** complete all information below and sign Replacement Notice on page 9. **APPLICANT A** Policy Number _____ Insurance Company Name _____ Insurance Company Address _____ **APPLICANT B** Policy Number _____ Insurance Company Name _____ Insurance Company Address _____	❑	❑

PART F PAYMENT SELECTIONS

APPLICANT A		APPLICANT B
	1. **Choose Standard Mode <u>OR</u> one of the Accelerated Payment Riders:**	
❑	Standard Mode	❑
	Accelerated Payment Riders*:	
❑	Double Pay First Year Rider	❑
❑	Reduced Pay at Age 65 Rider	❑
❑	Paid-Up Premiums Rider**	❑
❑	Ten Year Premium Payment Rider**	❑

*Not available with Future Purchase Rider.
*If the premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.
**If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.

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

APPLICANT A	**APPLICANT B**
Name _____	Name _____
Address _____	Address _____
City _____	City _____
State _____ Zip _____	State _____ Zip _____
Phone Number ( ) _____	Phone Number ( ) _____

❑	Monthly Automatic Checking Account Deduction	❑

Electronic Payment Agreement Authorization

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

APPLICANT A: Credit Union Phone Number ( ) _____

APPLICANT B: Credit Union Phone Number ( ) _____

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

APPLICANT A: By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

APPLICANT B: By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.

X _____ _____
Signature of Account Holder for **APPLICANT A** Date

X _____ _____
Signature of Account Holder for **APPLICANT B** Date

_____ **APPLICANT A** **APPLICANT B** _____

PART G AGREEMENT AND ACKNOWLEDGEMENT

APPLICANT A		APPLICANT B
	Required Information. Please check to indicate that you have received all of the following items:	
❑	Privacy Notice	❑
❑	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 elect NOT to designate a person to receive this notice.**	❑
❑	**I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:**	❑

Name _____
Address _____
City _____
State _____ Zip _____
Phone Number ( ) _____
Relationship _____

Name _____
Address _____
City _____
State _____ Zip _____
Phone Number ( ) _____
Relationship _____

❑	**Rejection of 5% Automatic Compound Inflation Protection Rider** (if applicable) I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection Rider.	❑
❑	**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.	❑
❑	**I authorize any refund or overpayment** to be applied to my spouse or domestic partner's policy. I understand that any balance remaining will be refunded to me pursuant to the terms of my policy.	❑

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

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, MetLife may have the right to deny benefits or rescind your coverage.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of fraud, 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 A**

_____
Date Signed at City, State

X _____
Signature of Licensed and Appointed Agent/Producer

_____
Date Signed at City, State

X _____
Signature of **APPLICANT B**

_____
Date Signed at City, State

X _____
Signature of Licensed and Appointed Agent/Producer

_____
Date Signed at City, State

VIP2APP-IND-OR

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

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

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE. SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance or long-term care insurance coverage and replace it with an individual long-term care insurance policy issued by Metropolitan Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care insurance coverage is a wise decision.

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

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

_____
Print Name of Licensed and Appointed Agent/Producer

X _____
Signature of Licensed and Appointed Agent/Producer

_____
Address of Licensed and Appointed Agent/Producer

X _____
Signature of **APPLICANT A** Date

X _____
Signature of **APPLICANT B** Date

APPLICANT A

MEDICAL AUTHORIZATION

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

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

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last seven 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 copy of this form is as valid as the original form.

Print Name of **APPLICANT A** _____ Date of Birth _____

X _____ Signature of **APPLICANT A** _____ Date _____

APPLICANT B

MEDICAL AUTHORIZATION

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

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

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last seven 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 copy of this form is as valid as the original form.

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

X _____ Date _____

Signature of **APPLICANT B**

Case Number(s) if known _____
(For sales office use only)

APPLICANT A

AUTHORIZATION TO RELEASE HEALTH-RELATED INFORMATION TO AGENT/PRODUCER

Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company
Metropolitan Tower Life Insurance Company
MetLife Insurance Company of Connecticut

I authorize the insurance companies named above (collectively "MetLife") to disclose information about me, including health-related information, to the insurance Agent/Producer named below for the purpose of providing me with additional information regarding the underwriting decision(s) made in connection with any application(s) I submit to any of the insurance companies named above for Life Insurance, Disability Income Insurance and Long-Term Care Insurance.

_____ _____
Print Name of Agent/Producer Print Business Address Agent/Producer

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include information contained in medical records such as test results, and data on my medical care, treatment or surgery and prescription medicines. Additional information that may be disclosed includes information regarding treatment for sexually transmitted diseases, mental illness, psychiatric or psychological disorders and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information regarding Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS) and HIV related conditions will not be disclosed under the terms of this Authorization.

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

I understand that:

- **I am not required to sign this Authorization as a condition of my application for insurance from MetLife.**
- **Signing or revoking this Authorization will not affect my treatment, payment, enrollment, or eligibility for MetLife insurance.**

I further understand that:

- This Authorization will cover applications for the products indicated above submitted to any of the insurance companies named above during the next 12 months, beginning on the date this Authorization is signed.
- 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 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 or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- This Authorization will be valid for 12 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to revoke this Authorization at any time and may do so by writing to: MetLife, P.O. Box 489, Warwick, RI 02887. 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.
- I have a right to receive a copy of this Authorization.

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

_____ _____
Print Name of **APPLICANT A** Date of Birth

If Applicant is under 18, the ❑ Parent or ❑ Guardian is to sign below for such child.

X _____ _____ _____
Signature of **APPLICANT A** Date Signed at City, State

As witness, I attest to having observed the party named above sign in my presence.

X _____
Witness to Signature

Case Number(s) if known _____
(For sales office use only)

APPLICANT B

AUTHORIZATION TO RELEASE HEALTH-RELATED INFORMATION TO AGENT/PRODUCER

Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company
Metropolitan Tower Life Insurance Company
MetLife Insurance Company of Connecticut

I authorize the insurance companies named above (collectively "MetLife") to disclose information about me, including health-related information, to the insurance Agent/Producer named below for the purpose of providing me with additional information regarding the underwriting decision(s) made in connection with any application(s) I submit to any of the insurance companies named above for Life Insurance, Disability Income Insurance and Long-Term Care Insurance.

_____ _____
Print Name of Agent/Producer Print Business Address Agent/Producer

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include information contained in medical records such as test results, and data on my medical care, treatment or surgery and prescription medicines. Additional information that may be disclosed includes information regarding treatment for sexually transmitted diseases, mental illness, psychiatric or psychological disorders and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information regarding Human Immunodeficiency Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS) and HIV related conditions will not be disclosed under the terms of this Authorization.

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

I understand that:

- **I am not required to sign this Authorization as a condition of my application for insurance from MetLife.**
- **Signing or revoking this Authorization will not affect my treatment, payment, enrollment, or eligibility for MetLife insurance.**

I further understand that:

- This Authorization will cover applications for the products indicated above submitted to any of the insurance companies named above during the next 12 months, beginning on the date this Authorization is signed.
- 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 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 or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- This Authorization will be valid for 12 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to revoke this Authorization at any time and may do so by writing to: MetLife, P.O. Box 489, Warwick, RI 02887. 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.
- I have a right to receive a copy of this Authorization.

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

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

If Applicant is under 18, the ❑ Parent or ❑ Guardian is to sign below for such child.

X _____ _____ _____
Signature of **APPLICANT B** Date Signed at City, State

As witness, I attest to having observed the party named above sign in my presence.

X _____
Witness to Signature

APPLICANT A

LTC BENEFICIARY DESIGNATION FORM

Applicant's Name:_____ Applicant's Social Security No:_____

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

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

❑ **Individual Beneficiary(ies) Designation**

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

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

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

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

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code_____

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

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

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

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

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

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

_____ **X**_____ _____

Print Name of **APPLICANT A** Signature of **APPLICANT A** Date

APPLICANT B

LTC BENEFICIARY DESIGNATION FORM

Applicant's Name:_____ Applicant's Social Security No:_____

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

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

❑ **Individual Beneficiary(ies) Designation**

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

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

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

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

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code_____

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

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

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

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

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

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

_____ **X**_____ _____
Print Name of **APPLICANT B** Signature of **APPLICANT B** Date

_____ **APPLICANT A** **APPLICANT B** _____

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

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

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

PREMIUM INFORMATION

Policy Form Number: LTC2-VAL, LTC2-IDEAL, LTC2-PREM, LTC2-FAC Policy Series

The premium for the coverage you are considering will be:

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

APPLICANT A ❑ $_____ per month, or ❑ $ _____per quarter, or ❑ $ _____semi-annually, or ❑ $ _____annually

APPLICANT B ❑ $_____ per month, or ❑ $ _____per quarter, or ❑ $ _____semi-annually, or ❑ $ _____annually

Type of Policy: Guaranteed Renewable

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

Rate Increase History: The company has sold long-term care insurance since 1986 and has sold this policy series since 2005. In 2009, MetLife applied a new premium rate schedule to individual long-term care insurance policy forms currently for sale in this and other states, where approved. Please note: The new premium rate schedules do not apply to any coverage that was in place prior to implementation of the new premium rates in that state. Your Agent/Producer can provide you with up-to-date information concerning the status of the approval of these new premium rate schedules in your particular state.

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

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

QUESTIONS RELATED TO YOUR INCOME

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

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

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

---

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

APPLICANT A ❑ Yes ❑ No

APPLICANT B ❑ Yes ❑ No

What is your annual income? (check one)

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

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

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

APPLICANT A ❑ No change ❑ Increase ❑ Decrease

APPLICANT B ❑ No change ❑ Increase ❑ Decrease

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

Will you buy inflation protection? (check one)

APPLICANT A ❑ Yes ❑ No

APPLICANT B ❑ Yes ❑ No

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET – *continued*

QUESTIONS RELATED TO YOUR INCOME (Continued)

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

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

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

The national average annual cost of Nursing Home care in 2008 was $69,715, but this figure varies across the country. In ten years the national average annual cost would be about $113,558 if costs increase 5% annually.

What elimination period are you considering?

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

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

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

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

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

QUESTIONS RELATED TO YOUR SAVINGS/INVESTMENTS

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

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

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

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

APPLICANT A ❑ Stay about the same ❑ Increase ❑ Decrease

APPLICANT B ❑ Stay about the same ❑ Increase ❑ Decrease

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

DISCLOSURE STATEMENT

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

The company may contact you to verify your answers.

AUTHORIZATION TO PROCEED PROCESSING APPLICATION

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

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

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

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

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

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

X _____ _____

Signature of **APPLICANT A** Date

X _____ _____

Signature of **APPLICANT B** Date

CONDITIONAL PREMIUM RECEIPT

Received from _____ Name of **APPLICANT A** (Please print) $_____ on _____ Check No. _____ Amount Date	Received from _____ Name of **APPLICANT B** (Please print) $_____ on _____ Check No. _____ Amount Date

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

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

1. If, after we (Metropolitan Life Insurance Company ("MetLife") receive: (a) the Initial Application Requirements, as defined below; and (b) evidence of insurability acceptable to us, determine that as of the date of the application, you are insurable based upon our underwriting criteria and standards for the insurance coverage applied for, the policy will take effect. **In the event that all of the conditions in the preceding sentence are satisfied, coverage under this Conditional Receipt will take effect on the Application Date and the coverage shall be governed by the terms and conditions of the policy applied for in the application.** Any changes in your health after the date of this Receipt will not affect our underwriting decision.
2. If we issue a policy to you, any unpaid balance of the first full premium due, in accordance with the premium payment mode you have selected, must be paid upon delivery of the policy.

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

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

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

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

LIMITATIONS ON AUTHORITY: No one but the President, the Secretary or a Vice-President of MetLife may change or waive the terms of this Conditional Premium Receipt. No Agent/Producer, financial services representative or medical examiner has authority to determine insurability or to make or modify any contract of insurance or waive any of our requirements.

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

X _____ _____ Signature of **APPLICANT A** Date No Agent/Producer or financial services representative is authorized to accept any payment with the application if you answered **YES** (or left blank) to any of the questions in Part C of your application. Receipt of $ _____ is acknowledged from _____ in connection with the application for Long-Term Care Insurance on this date _____ By: **X** _____ Signature of Licensed & Appointed Agent/Producer	**X** _____ _____ Signature of **APPLICANT B** Date No Agent/Producer or financial services representative is authorized to accept any payment with the application if you answered **YES** (or left blank) to any of the questions in Part C of your application. Receipt of $ _____ is acknowledged from _____ in connection with the application for Long-Term Care Insurance on this date _____ By: **X** _____ Signature of Licensed & Appointed Agent/Producer

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.**

_____ **APPLICANT A** **APPLICANT B** _____

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

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

AGENT/PRODUCER'S REPORT – *continued*

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

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

❑ I did not personally interview, by phone or face-to-face, the Applicant(s). I certify that any required written disclosure statement was given to the Applicant(s) no later than the date this application was signed. I am certified to represent and sell this MetLife Long-Term Care approved product. (This includes any licenses, appointments, CE's, or Partnership certifications.)

_____ _____

Print Name of Primary Licensed & Appointed Agent/Producer | Signature of Primary Licensed & Appointed Agent/Producer

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

Office ID# _____ Producer # _____ SS# _____

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

Address _____ City _____ State _____ Zip _____

Phone/Fax ( ) _____ E-mail address _____

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

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

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

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

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

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

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

MGA Phone Number ( ) _____ Fax Number ( ) _____

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

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

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

	IF SPLIT
AGA _____	AGA _____
GA1 _____	GA1 _____
Broker _____	Broker _____

Enter "pending" if code not yet assigned.

MetLife®

Metropolitan Life Insurance Company
New York, NY

order #:
VIP2APP-IND-OR (0310)