

Long-Term Care Insurance (LTCI)

Long-Term Care Insurance

Individual Application & Important Forms



MetLife[®]

For use in the state of
CALIFORNIA

Metropolitan Life Insurance Company
New York, NY 10166

IMPORTANT INSTRUCTIONS FOR AGENTS

- Complete all application pages. Tear out all GOLD application pages and return them to MetLife. GREY application pages stay with the applicant.
- All applicants between the ages of 56 - 74 will require a phone health interview. Other applicants may be contacted at the underwriter's discretion. The call is initiated by a Registered 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 of physicians
 - Dates of any surgeries or hospitalizations
- Please indicate under *Part D: DETAILS*, the best time to reach your client. All applicants between the ages of 75-84 will require a face-to-face interview and assessment. Medical records from the primary physician are required on all applicants age 61 and older or at the underwriter's discretion for age 60 and younger.
- If you are collecting premium payment at time of application, you must only collect:
 - ✓ 1 months minimum if client elects monthly Electronic Payment Deduction
- The Beneficiary Designation Form for the Return of Premium Rider should only be completed if the Applicant is selecting the Return of Premium Rider and chooses to designate a beneficiary other than their estate.

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance

A Long-Term Care Insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy thoroughly and make sure you understand what it covers before you purchase.

- You should **not** purchase this policy unless you can afford to pay the premiums every year. Remember that the company may increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

Medicare is **not** designed to pay for long-term care.

Medi-Cal

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

- Many people become eligible for Medi-Cal after they have exhausted their own financial resources paying for long-term care services.
- When Medi-Cal pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medi-Cal. To learn more about Medi-Cal, contact your local or state Medi-Cal agency.

Shopper's Guide

Make sure the insurance company or agent gives you a copy of a book called the "Taking Care of Tomorrow A Consumer's Guide to Long Term Care." Read it carefully. If you have decided to apply for Long-Term Care Insurance, you have the right to return the policy within 30 days and receive a full refund of any premium you had paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

Free counseling and additional information about Long-Term Care Insurance is available through California's state insurance counseling program. Contact your CA Insurance Department or Department on Aging for more information about the senior health insurance counseling program in your state.

LEAVE THIS PAGE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK.

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

APPLICANT 1 NAME:

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 get. Others don't want their family to have to pay for care or don't want to go on Medi-Cal. 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(s)

The premium for the coverage you are considering will be: \$ per month, or \$ per year.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program's (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet web site (www.insurance.ca.gov).

TYPE OF POLICY: Guaranteed Renewable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

RATE INCREASE HISTORY: The company has sold long-term care insurance since 1986, and has sold this policy since 2005. MetLife has never increased its rates for long-term care insurance offered by agents to individuals, for long-term care insurance sponsored by employer groups, or for long-term care insurance endorsed by associations. MetLife has only increased its rates for long-term care insurance covering residents of two Continuing Care Retirement Communities (CCRCs). Each increase shown below affected less than 0.6% of MetLife's total long-term care insurance business.

<u>CCRC</u>	<u>Group Policy Form</u>	<u>Years Available</u>	<u>Year(s) of Increase</u>	<u>Percentage of Increase</u>
Community A	#G.9708	1986-97	1995-97	10% each year
Community B	#G.9873	1989-98	1999	9%-38%

QUESTIONS RELATED TO YOUR INCOME

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

From my Income From my Savings/Investments Family members

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

What is your annual income? (check one) Under \$10,000 \$10,000 - \$19,999 \$20,000 - \$29,999
 \$30,000 - \$49,999 Over \$50,000

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

No change Increase Decrease

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

Have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments Family members

The national average annual cost of nursing facility care in 2004 was \$61,685, but this figure varies across the country. In ten years the national average annual cost would be about \$100,478 if costs increase 5% annually.¹

¹“MetLife Mature Market Institute. “The MetLife Market Survey of Nursing Home and Home Care Costs,” September 2004.

MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET (CONTINUED)

APPLICANT 1

QUESTIONS RELATED TO YOUR INCOME (CONTINUED)

What elimination period are you considering?

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)

- From my Income From my Savings/Investments Family members

QUESTIONS RELATED TO YOUR SAVING/INVESTMENTS

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

- Under \$20,000 \$20,000 - \$29,999 \$30,000 - \$49,999 Over \$50,000

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

- No change Increase Decrease

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

DISCLOSURE STATEMENT

APPLICANT 1 If the applicant elects not to disclose any information in the Personal Worksheet, he/she is still required to sign and date below. (check one):

- The answers to the questions above describe my financial situation

or

- I choose not to disclose this information

- (this box must be checked)** I acknowledge that the carrier and/or its agent (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.**



Date:

Signature of Applicant 1

AGENT

- I explained to the applicant the importance of completing this information.



Date:

Signature of Authorized Agent

Agent's Printed Name:

In order for us to process your application, please return this signed statement to MetLife, along with your application.

IF APPLICABLE

- My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.



Date:

Signature of Applicant 1

The company may contact you to verify your answers.

SIGN & MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

APPLICANT 2 NAME:

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 get. Others don't want their family to have to pay for care or don't want to go on Medi-Cal. 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(s)

The premium for the coverage you are considering will be: \$ per month, or \$ per year.

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increases, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program's (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet web site (www.insurance.ca.gov).

TYPE OF POLICY: Guaranteed Renewable

THE COMPANY'S RIGHT TO INCREASE PREMIUMS: The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

RATE INCREASE HISTORY: The company has sold long-term care insurance since 1986, and has sold this policy since 2005. MetLife has never increased its rates for long-term care insurance offered by agents to individuals, for long-term care insurance sponsored by employer groups, or for long-term care insurance endorsed by associations. MetLife has only increased its rates for long-term care insurance covering residents of two Continuing Care Retirement Communities (CCRCs). Each increase shown below affected less than 0.6% of MetLife's total long-term care insurance business.

CCRC	Group Policy Form	Years Available	Year(s) of Increase	Percentage of Increase
Community A	#G.9708	1986-97	1995-97	10% each year
Community B	#G.9873	1989-98	1999	9%-38%

QUESTIONS RELATED TO YOUR INCOME

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

From my Income From my Savings/Investments Family members

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

What is your annual income? (check one) Under \$10,000 \$10,000 - \$19,999 \$20,000 - \$29,999
 \$30,000 - \$49,999 Over \$50,000

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

No change Increase Decrease

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

Have you considered how you will pay for the difference between future costs and your daily benefit amount?

From my Income From my Savings/Investments Family members

The national average annual cost of nursing facility care in 2004 was \$61,685, but this figure varies across the country. In ten years the national average annual cost would be about \$100,478 if costs increase 5% annually.¹

¹ "MetLife Mature Market Institute. "The MetLife Market Survey of Nursing Home and Home Care Costs," September 2004.

MAIL THIS PAGE TO METLIFE

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET (CONTINUED)

APPLICANT 2

QUESTIONS RELATED TO YOUR INCOME (CONTINUED)

What elimination period are you considering?

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)

- From my Income From my Savings/Investments Family members

QUESTIONS RELATED TO YOUR SAVING/INVESTMENTS

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

- Under \$20,000 \$20,000 - \$29,999 \$30,000 - \$49,999 Over \$50,000

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

- No change Increase Decrease

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

DISCLOSURE STATEMENT

APPLICANT 2 If the applicant elects not to disclose any information in the Personal Worksheet, he/she is still required to sign and date below. (check one):

- The answers to the questions above describe my financial situation
or
 I choose not to disclose this information

(this box must be checked) I acknowledge that the carrier and/or its agent (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.**



Date:

Signature of Applicant 2

AGENT

I explained to the applicant the importance of completing this information.



Date:

Signature of Authorized Agent

Agent's Printed Name:

In order for us to process your application, please return this signed statement to MetLife, along with your application.

IF APPLICABLE

My agent has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.



Date:

Signature of Applicant 2

The company may contact you to verify your answers.

SIGN & MAIL THIS PAGE TO METLIFE

TABLE OF CONTENTS

PART A	Person(s) Applying for Coverage	1-2
PART B	Insurability Questions	4
PART C	Coverage Selections.....	5-6
PART D	Health Questions	7-11
PART E	How You Want to Pay Premiums	12-13
PART F	Replacement Questions	15
PART G	Agreement and Acknowledgement.....	17-19
AR	Agent’s Report	20-21
CR	Conditional Receipt	
	Applicant 1	23-26
	Applicant 2	29-30
AUTH	Authorization to Release Information	
	Applicants 1 & 2	31-35
CPN	Consumer Privacy Notice	
	Applicant 1	37-38
	Applicant 2	39-40
RPN	Replacement Notice	
	Applicant 1	39
	Applicant 2	41
BDF	Beneficiary Designation Form	
	Applicant 1	43-44
	Applicant 2	45-46
RCL	Replacement Checklist	
	Applicant 1	49-50
	Applicant 2	51-52

Application for Individual Long-Term Care Insurance

AGENT

All GOLD pages, the Authorization and, if a replacement policy, the Replacement Notice must be submitted to:
 Metropolitan Life Insurance Company Individual Long-Term Care
 Payment Enclosed: \$ _____



Metropolitan Life Insurance Company
 New York, NY 10166

THIS PAGE IS INTENTIONALLY LEFT BLANK.

PART A

PERSON(S) APPLYING FOR COVERAGE

THE POLICY IS AN APPROVED LONG-TERM CARE INSURANCE CONTRACT UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THE POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG-TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1 (800) 434-0222.

The Contract for Long-Term Care Insurance is intended to be a federally qualified Long-Term Care Insurance contract and may qualify you for federal and state tax benefits.

Please complete ALL information for EACH applicant below.

APPLICANT 1	APPLICANT 2
<p><input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)</p>	<p><input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)</p>
<p>1. _____ First Name Middle Initial</p>	<p>1. _____ First Name Middle Initial</p>
<p>2. _____ Last Name</p>	<p>2. _____ Last Name</p>
<p>3. _____ Address Apt. #</p>	<p>3. _____ Address Apt. #</p>
<p>4. _____ City State Zip</p>	<p>4. _____ City State Zip</p>
<p>5. _____ Home Phone</p>	<p>5. _____ Home Phone</p>
<p>6. _____ Work Phone</p>	<p>6. _____ Work Phone</p>
<p>7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>	<p>7. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female</p>

MAIL THIS PAGE TO METLIFE

PART A

PERSON(S) APPLYING FOR COVERAGE (CONTINUED)

APPLICANT 1	APPLICANT 2
<p>8. Date of Birth: <input type="text"/> (MM/DD/YYYY)</p> <p>9. Social Security #: <input type="text"/></p>	<p>8. Date of Birth: <input type="text"/> (MM/DD/YYYY)</p> <p>9. Social Security #: <input type="text"/></p>
<p>10. Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner* (Please check "Single" if you are widowed or divorced.)</p>	<p>10. Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner* (Please check "Single" if you are widowed or divorced.)</p>
<p>11. Is your Spouse or Domestic Partner* applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" your Spouse's or Domestic Partner's*:</p> <p>12. Name: _____ Social Security #: _____</p> <p>13. Is any other member of your household applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES"</p> <p>14. Name: _____ Social Security #: _____</p>	<p>11. Is your Spouse or Domestic Partner* applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" your Spouse's or Domestic Partner's*:</p> <p>12. Name: _____ Social Security #: _____</p> <p>13. Is any other member of your household applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES"</p> <p>14. Name: _____ Social Security #: _____</p>
<p>15. This is a request for: <input type="checkbox"/> Initial Coverage <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Re-apply</p>	<p>15. This is a request for: <input type="checkbox"/> Initial Coverage <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Re-apply</p>
<p>*"Domestic Partner" means each of two people: who have registered or filed as Domestic Partners or members of a civil union with a government agency or office where such registration is available; or who meet the following requirements: each person is 18 years of age or older; neither person is married; they share the same residence; they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and they have an exclusive mutual commitment to share the responsibility to each other's welfare and financial obligations and such commitment is expected to last indefinitely.</p>	

MAIL THIS PAGE TO METLIFE

PART B

INSURABILITY QUESTIONS

Please answer these questions **BEFORE** you continue with other parts of this Application.

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
1. Have you had, do you currently have, have you ever been medically diagnosed as having or have you been treated for:				
a. Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Dementia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Frequent or persistent forgetfulness that is progressive or for which you take medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Mental retardation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Parkinson's disease or syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Amyotrophic lateral sclerosis (Lou Gehrig's disease)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Muscular dystrophy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Stroke or any other type of cerebral vascular accident (CVA) within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Multiple strokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Stroke with residual impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Transient ischemic attack (TIA) within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Multiple transient ischemic attacks (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. AIDS related complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Immune deficiency disorder (except HIV infection)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Cancer that has spread to another area of your body, including lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Cancer treated in past 24 months (except basal cell or squamous cell cancer of the skin or early stage breast or prostate cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Cirrhosis of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Any chronic respiratory disease, in combination with smoking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u. Congestive heart failure for which you are currently being treated (including treatment by medication)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MAIL THIS PAGE TO METLIFE

PART B

INSURABILITY QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
v. Diabetes with Physician diagnosed complication (except Retinopathy)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Any mental or nervous disorder for which you have been hospitalized in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. Any mental or nervous disorder for which you have had multiple hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had, or do you plan to have, any organ transplant (except corneal transplant)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you require human assistance or supervision for any of the following activities:				
a. bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. dressing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. eating?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. getting in or out of bed or a chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. use of toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. bowel or bladder control?.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently use a				
a. wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. motorized scooter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. walker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. quad cane?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. oxygen treatment for respiratory disease or heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you currently residing in a Nursing Facility or Residential Care Facility or Residential Care Facility for the elderly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you currently receiving home health care services or attending adult day health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered “YES” to any part of PART B, questions 1-6, PLEASE DO NOT CONTINUE.

We regret that we cannot offer you Long-Term Care Insurance coverage.

If you answered “NO” to all of PART B, questions 1-5 please CONTINUE...

MAIL THIS PAGE TO METLIFE

PART C

COVERAGE SELECTIONS YOU ARE APPLYING FOR

APPLICANT 1	APPLICANT 2
<p>1. Select Your Plan of Coverage:</p> <p><input type="checkbox"/> Value <input type="checkbox"/> Ideal <input type="checkbox"/> Premier <input type="checkbox"/> Nursing Facility/Residential Care Facility-Only</p>	<p>1. Select Your Plan of Coverage:</p> <p><input type="checkbox"/> Value <input type="checkbox"/> Ideal <input type="checkbox"/> Premier <input type="checkbox"/> Nursing Facility/Residential Care Facility-Only</p>
<p>2. Select Your Maximum Nursing Home Daily Benefit Amount ("DBA"):</p> <p>DBA: \$ <input type="text"/> (\$90 to \$400 per day, in \$10 increments)</p> <p>Note: \$100 minimum DBA required if selecting the Ideal policy.</p>	<p>2. Select Your Maximum Nursing Home Daily Benefit Amount ("DBA"):</p> <p>DBA: \$ <input type="text"/> (\$90 to \$400 per day, in \$10 increments)</p> <p>Note: \$100 minimum DBA required if selecting the Ideal policy.</p>
<p>3. Select Your Benefit Period Multiplier: (Your Total Lifetime Benefit = Benefit Period X DBA)</p> <p><input type="checkbox"/> 365 (1-year) <input type="checkbox"/> 730 (2-year) <input type="checkbox"/> 1,095 (3-year) <input type="checkbox"/> 1,460 (4-year) <input type="checkbox"/> 1,825 (5-year) <input type="checkbox"/> 2,555 (7-year) <input type="checkbox"/> Unlimited* (available through age 79)</p> <p>*Unlimited Benefit Period – Not Available with Premier</p>	<p>3. Select Your Benefit Period Multiplier: (Your Total Lifetime Benefit = Benefit Period X DBA)</p> <p><input type="checkbox"/> 365 (1-year) <input type="checkbox"/> 730 (2-year) <input type="checkbox"/> 1,095 (3-year) <input type="checkbox"/> 1,460 (4-year) <input type="checkbox"/> 1,825 (5-year) <input type="checkbox"/> 2,555 (7-year) <input type="checkbox"/> Unlimited* (available through age 79)</p> <p>*Unlimited Benefit Period – Not Available with Premier</p>
<p>4. Select the percentage of DBA to be paid for Primary Services: <i>Do not select any of the following if a Nursing Facility/Residential Care Facility-Only Policy is chosen</i></p> <p>a. For Value, select your Home Care and Residential Care Facility paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75%</p> <p>b. For Ideal, select your Home Care paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% (\$100 minimum DBA required)</p> <p>c. For Premier, select your Basic Daily Benefit paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50%</p> <p style="text-align: right;"><i>(continued)</i></p>	<p>4. Select the percentage of DBA to be paid for Primary Services: <i>Do not select any of the following if a Nursing Facility/Residential Care Facility-Only Policy is chosen</i></p> <p>a. For Value, select your Home Care and Residential Care Facility paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75%</p> <p>b. For Ideal, select your Home Care paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50% (\$100 minimum DBA required)</p> <p>c. For Premier, select your Basic Daily Benefit paid at: <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50%</p> <p style="text-align: right;"><i>(continued)</i></p>

MAIL THIS PAGE TO METLIFE

PART C

COVERAGE SELECTIONS YOU ARE APPLYING FOR (CONTINUED)

APPLICANT 1	APPLICANT 2
<p>5. Select an Elimination Period:</p> <p><input type="checkbox"/> 20 Days <input type="checkbox"/> 45 Days <input type="checkbox"/> 100 Days</p>	<p>5. Select an Elimination Period:</p> <p><input type="checkbox"/> 20 Days <input type="checkbox"/> 45 Days <input type="checkbox"/> 100 Days</p>
<p>6. Select Optional Riders:</p> <p><input type="checkbox"/> Indemnity Rider (Available with Value policy only)</p> <p><input type="checkbox"/> Shared Care Rider Spouse/Domestic Partner must have identical coverage (Not available with Restoration of Benefits Rider)</p> <p><input type="checkbox"/> Paid-Up Survivorship Rider</p> <p><input type="checkbox"/> Calendar Day Rider (Only available with Value & Ideal policies; Not available with Home Care EP Waiver)</p> <p><input type="checkbox"/> Home Care EP Waiver (Only available with Value & Ideal policies; Not available with Calendar Day Rider)</p> <p><input type="checkbox"/> Restoration of Benefits Rider (Not available with Premier Policy or Shared Care Rider or Unlimited Benefit Period)</p> <p><input type="checkbox"/> Return of Premium Rider To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.</p>	<p>6. Select Optional Riders:</p> <p><input type="checkbox"/> Indemnity Rider (Available with Value policy only)</p> <p><input type="checkbox"/> Shared Care Rider Spouse/Domestic Partner must have identical coverage (Not available with Restoration of Benefits Rider)</p> <p><input type="checkbox"/> Paid-Up Survivorship Rider</p> <p><input type="checkbox"/> Calendar Day Rider (Only available with Value & Ideal policies; Not available with Home Care EP Waiver)</p> <p><input type="checkbox"/> Home Care EP Waiver (Only available with Value & Ideal policies; Not available with Calendar Day Rider)</p> <p><input type="checkbox"/> Restoration of Benefits Rider (Not available with Premier Policy or Shared Care Rider or Unlimited Benefit Period)</p> <p><input type="checkbox"/> Return of Premium Rider To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife.</p>
<p>7. Benefit Increase Options (choose one):</p> <p><input type="checkbox"/> 5% Automatic Compound Inflation Protection Rider</p> <p><input type="checkbox"/> 5% Automatic Simple Benefit Increase Rider</p> <p><input type="checkbox"/> Future Purchase Rider*</p> <p><input type="checkbox"/> No Inflation Protection Rider</p> <p>* Not available if an Accelerated Premium Payment Rider is selected.</p>	<p>7. Benefit Increase Options (choose one):</p> <p><input type="checkbox"/> 5% Automatic Compound Inflation Protection Rider</p> <p><input type="checkbox"/> 5% Automatic Simple Benefit Increase Rider</p> <p><input type="checkbox"/> Future Purchase Rider*</p> <p><input type="checkbox"/> No Inflation Protection Rider</p> <p>* Not available if an Accelerated Premium Payment Rider is selected.</p>
<p>8. Nonforfeiture Coverage Rider:</p> <p>I Select Nonforfeiture Coverage Rider</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>8. Nonforfeiture Coverage Rider:</p> <p>I Select Nonforfeiture Coverage Rider</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

MAIL THIS PAGE TO METLIFE

PART D

HEALTH QUESTIONS

APPLICANT 1	APPLICANT 2			
PRIMARY PHYSICIAN who has most of your medical records:	PRIMARY PHYSICIAN who has most of your medical records:			
Name: _____	Name: _____			
Telephone: (_____)_____	Telephone: (_____)_____			
Address: _____	Address: _____			
City: _____	City: _____			
State: _____ Zip: _____	State: _____ Zip: _____			
	APPLICANT 1	APPLICANT 1	APPLICANT 2	APPLICANT 2
1. Have you had, do you currently have, have you been medically diagnosed as having or have you been treated for:	Yes	No	Yes	No
a. Cancer (except basal cell cancer or squamous cell cancer of the skin)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Arrhythmia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Angina?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Heart surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Angioplasty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Stroke or any other type of Cerebral Vascular Accident (CVA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Transient Ischemic Attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Chronic lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Chronic liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Chronic kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Diabetes – insulin or non-insulin dependent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Chronic neurological disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Seizure disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r. Condition of the spine or peripheral nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s. Psychiatric disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t. Depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MAIL THIS PAGE TO METLIFE

PART D

HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
u. Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. Muscle disorder (e.g., fibromyalgia)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w. Immune system disorder (except HIV infection)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x. Connective tissue disorder (e.g., Scleroderma)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y. Lupus erythematosus?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
z. Amputation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
aa. Osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bb. Joint replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cc. Fractured hip?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dd. More than one fractured bone in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ee. Any falls in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ff. Paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gg. Weakness of extremities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hh. Numbness of extremities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. Tremors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
jj. Imbalance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
kk. Gait disturbance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ll. Dizziness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mm. Memory loss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently use any medical equipment (e.g., cane, brace, crutches, or stair lift)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you require assistance in activities such as				
a. shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. managing finances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. meal preparation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. laundry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. taking your medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MAIL THIS PAGE TO METLIFE

PART D

HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
4. Are you currently receiving any				
a. disability income?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. worker's compensation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. social security disability income?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. federal or state disability payments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had an application for				
Life Insurance:				
a. declined?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. postponed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. rated less than standard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Insurance:				
d. declined?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. postponed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. rated less than standard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Care Insurance:				
g. declined?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. postponed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. rated less than standard?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever resided in or been advised to enter a				
a. nursing facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. residential care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. residential care facility for the elderly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. retirement community?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever received home health care services or attended adult day health care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last 2 years, have you been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had any past surgeries, or do you plan to have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been advised to seek medical attention for any symptoms, testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MAIL THIS PAGE TO METLIFE

PART D

HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
11. Have you taken any prescription medications during the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IF "YES" to Part D question 11, please list medications below.
Please use additional paper, if necessary.

APPLICANT 1

APPLICANT 2

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

Medication: _____
 Prescribing Physician: _____

(continued)

(continued)

MAIL THIS PAGE TO METLIFE

PART D

HEALTH QUESTIONS (CONTINUED)

	APPLICANT 1		APPLICANT 2	
	Yes	No	Yes	No
12. Have you used tobacco products within the last 2 years? IF "YES" date of last use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____		_____	
13. Do you currently use alcoholic beverages? IF "YES" How often? How much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____		_____	
	_____		_____	
14. Have you ever been treated, hospitalized or counseled for the use of alcohol or controlled substances? IF "YES" date of treatment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	_____		_____	
15. What is your height? (in inches)	_____		_____	
16. What is your weight? (in pounds)	_____		_____	

APPLICANT 1

17. Do you:

a. exercise? Yes No
IF "YES" please describe: _____

b. drive a motor vehicle? Yes No
IF "YES" how many miles per week? _____

c. work outside the home? Yes No
IF "YES" please describe: _____

d. do volunteer work? Yes No
IF "YES" please describe: _____

e. have hobbies? Yes No
IF "YES" please describe: _____

(continued)

APPLICANT 2

17. Do you:

a. exercise? Yes No
IF "YES" please describe: _____

b. drive a motor vehicle? Yes No
IF "YES" how many miles per week? _____

c. work outside the home? Yes No
IF "YES" please describe: _____

d. do volunteer work? Yes No
IF "YES" please describe: _____

e. have hobbies? Yes No
IF "YES" please describe: _____

(continued)

MAIL THIS PAGE TO METLIFE

PART E

HOW YOU WANT TO PAY PREMIUMS

APPLICANT 1

1. Choose only ONE Premium Payment Option:

- 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

2. Choose any ONE of the payment methods and modes below.

Please note that paying insurance premiums more often than annually will cost more than paying them once a year. (e.g.: If premium is \$1,000 Annually – selecting Quarterly would increase your Annual premium by \$60.)

a. Direct Bill (Select premium mode):

- Annually
- Semi-Annually (2% more than Annually)
- Quarterly (6% more than Annually)
- Monthly Automatic Checking Account Deduction (complete Part E, #3) (8% more than Annually)

**b. Third-party payer (if applicable):
Select premium mode:**

- Annually
- Semi-Annually (2% more than Annually)
- Quarterly (6% more than Annually)

FOR A OR B MAIL BILL TO:

Full Name: _____
 Address: _____
 Apt. # _____ City: _____
 State: _____ Zip: _____
 Telephone: (_____) _____

(continued)

APPLICANT 2

1. Choose only ONE Premium Payment Option:

- 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

2. Choose any ONE of the payment methods and modes below.

Please note that paying insurance premiums more often than annually will cost more than paying them once a year. (e.g.: If premium is \$1,000 Annually – selecting Quarterly would increase your Annual premium by \$60.)

a. Direct Bill (Select premium mode):

- Annually
- Semi-Annually (2% more than Annually)
- Quarterly (6% more than Annually)
- Monthly Automatic Checking Account Deduction (complete Part E, #3) (8% more than Annually)

**b. Third-party payer (if applicable):
Select premium mode:**

- Annually
- Semi-Annually (2% more than Annually)
- Quarterly (6% more than Annually)

FOR A OR B MAIL BILL TO:

Full Name: _____
 Address: _____
 Apt. # _____ City: _____
 State: _____ Zip: _____
 Telephone: (_____) _____

(continued)

MAIL THIS PAGE TO METLIFE

PART E

HOW YOU WANT TO PAY PREMIUMS (CONTINUED)

APPLICANT 1

ELECTRONIC PAYMENT AGREEMENT AUTHORIZATION

3. **Automatic Checking Account Deduction (Monthly):**

Your monthly premium will be deducted automatically from the bank or credit union checking account you request.



If you are submitting cash with your application you must enclose one month's premium. Enclose a voided blank check for the account you wish to use.

If using a credit union account, please provide credit union phone number.

Phone #: (_____) _____

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. 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.



Signature of Account Holder for
Monthly Automatic Deductions

Date

APPLICANT 2

ELECTRONIC PAYMENT AGREEMENT AUTHORIZATION

3. **Automatic Checking Account Deduction (Monthly):**

Your monthly premium will be deducted automatically from the bank or credit union checking account you request.



If you are submitting cash with your application you must enclose one month's premium. Enclose a voided blank check for the account you wish to use.

If using a credit union account, please provide credit union phone number.

Phone #: (_____) _____

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. 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.



Signature of Account Holder for
Monthly Automatic Deductions

Date

SIGN & MAIL THIS PAGE TO METLIFE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

PART F

REPLACEMENT QUESTIONS

You **MUST** answer all questions or We will not be able to process this application.
 State regulations require that We ask the following questions if you are applying for insurance.

APPLICANT 1	APPLICANT 2
<p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" the types and amounts of coverage?</p> <p>_____</p> <p>_____</p>	<p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" the types and amounts of coverage?</p> <p>_____</p> <p>_____</p>
<p>2. Did you have another Long-Term Care Insurance policy or certificate in-force during the last twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" with which insurance company?</p> <p>_____</p> <p>_____</p> <p>If that policy or certificate lapsed, when did it lapse?</p> <p>_____</p> <p>_____</p> <p>Is the policy in-force under a nonforfeiture benefit provision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2. Did you have another Long-Term Care Insurance policy or certificate in-force during the last twelve (12) months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" with which insurance company?</p> <p>_____</p> <p>_____</p> <p>If that policy or certificate lapsed, when did it lapse?</p> <p>_____</p> <p>_____</p> <p>Is the policy in-force under a nonforfeiture benefit provision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Are you covered under Medi-Cal? ("Medi-Cal" is different from "Medicare.") <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>3. Are you covered under Medi-Cal? ("Medi-Cal" is different from "Medicare.") <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" please complete all information below and sign Replacement Notice in back of application:</p> <p>Policy #: _____</p> <p>Insurance Company Name: _____</p> <p>Insurance Company Address: _____</p> <p>_____</p> <p>_____</p>	<p>4. Do you intend to replace any of your long-term care, medical or health insurance coverages with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" please complete all information below and sign Replacement Notice in back of application:</p> <p>Policy #: _____</p> <p>Insurance Company Name: _____</p> <p>Insurance Company Address: _____</p> <p>_____</p> <p>_____</p>

MAIL THIS PAGE TO METLIFE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

PART G

AGREEMENT AND ACKNOWLEDGEMENT

APPLICANT 1

REQUIRED INFORMATION

Please check to indicate that the Agent has delivered the following items:

- Outline of Coverage for the policy applied for, which includes a graphic comparison of a policy with and without the 5% Automatic Compound Inflation Protection Rider
- Taking Care of Tomorrow (Shopper’s Guide to Long-Term Care)
- If this is a replacement policy, Replacement Notice
- MetLife’s Consumer Privacy Notice
- HICAP Notice
- Long-Term Care Insurance Personal Worksheet
- Inflation Protection Disclosure Statement
- Information, including address and phone number of local HICAP office
- Guide to Health Insurance for People with Medicare (if eligible for Medicare)

SIGN _____
Signature of Applicant 1

Date

I have delivered all of the above documents to the Applicant.

SIGN _____
Signature of Licensed and Appointed Agent

Date

(continued)

APPLICANT 2

REQUIRED INFORMATION

Please check to indicate that the Agent has delivered the following items:

- Outline of Coverage for the policy applied for, which includes a graphic comparison of a policy with and without the 5% Automatic Compound Inflation Protection Rider
- Taking Care of Tomorrow (Shopper’s Guide to Long-Term Care)
- If this is a replacement policy, Replacement Notice
- MetLife’s Consumer Privacy Notice
- HICAP Notice
- Long-Term Care Insurance Personal Worksheet
- Inflation Protection Disclosure Statement
- Information, including address and phone number of local HICAP office
- Guide to Health Insurance for People with Medicare (if eligible for Medicare)

SIGN _____
Signature of Applicant 2

Date

I have delivered all of the above documents to the Applicant.

SIGN _____
Signature of Licensed and Appointed Agent

Date

(continued)

SIGN & MAIL THIS PAGE TO METLIFE

PART G

AGREEMENT AND ACKNOWLEDGEMENT (CONTINUED)

APPLICANT 1	APPLICANT 2
<p>1. Protection Against Unintended Lapse</p> <p>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.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium: Full Name: _____ Relationship: _____ Address: _____ Apt.# _____ Telephone: (____) _____ City: _____ State: _____ Zip: _____ </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input type="checkbox"/> I elect NOT to designate any person to receive the notice. </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Rejection of Compound Inflation Protection</p> <input type="checkbox"/> 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 options for Compound increase, and I reject the 5% Automatic Compound Inflation Protection Rider. </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Rejection of Nonforfeiture</p> <input type="checkbox"/> I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider. </div> <p style="text-align: right; font-style: italic;">(continued)</p>	<p>1. Protection Against Unintended Lapse</p> <p>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.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium: Full Name: _____ Relationship: _____ Address: _____ Apt.# _____ Telephone: (____) _____ City: _____ State: _____ Zip: _____ </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input type="checkbox"/> I elect NOT to designate any person to receive the notice. </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Rejection of Compound Inflation Protection</p> <input type="checkbox"/> 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 options for Compound increase, and I reject the 5% Automatic Compound Inflation Protection Rider. </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Rejection of Nonforfeiture</p> <input type="checkbox"/> I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider. </div> <p style="text-align: right; font-style: italic;">(continued)</p>

MAIL THIS PAGE TO METLIFE

PART G

AGREEMENT AND ACKNOWLEDGEMENT (CONTINUED)

APPLICANT 1

I understand that if this is an application for a new policy (Initial Coverage), then 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 premium 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 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 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 below.


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

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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read the above answers and statements on this Application. I declare all information supplied in this application is true and complete.

	_____
	Signature of Applicant 1

	Date
	Signed at City, State
	_____
	Signature of Licensed and Appointed Agent

	Date
	Signed at City, State

APPLICANT 2

I understand that if this is an application for a new policy (Initial Coverage), then 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 premium 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 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 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 below.


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

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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I have read the above answers and statements on this Application. I declare all information supplied in this application is true and complete.

	_____
	Signature of Applicant 2

	Date
	Signed at City, State
	_____
	Signature of Licensed and Appointed Agent

	Date
	Signed at City, State

SIGN & MAIL THIS PAGE TO METLIFE

AGENT'S REPORT

PLEASE PROVIDE COMPLETE DETAILS TO ENSURE AGAINST DELAYS IN PROCESSING THIS APPLICATION.

APPLICANT 1	APPLICANT 2
<p>1. Did you personally interview the Applicant face to face and witness his or her signature? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "NO" give details: _____ _____ _____</p>	<p>1. Did you personally interview the Applicant face to face and witness his or her signature? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "NO" give details: _____ _____ _____</p>
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" please describe: _____ _____ _____</p>	<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IF "YES" please describe: _____ _____ _____</p>
<p>3. Please list other health insurance policies sold by you to the Applicant that are still in-force:</p> <p>_____</p>	<p>3. Please list other health insurance policies sold by you to the Applicant that are still in-force:</p> <p>_____</p>
<p>4. List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force:</p> <p>_____</p>	<p>4. List health insurance policies sold by you in the last five years to the Applicant that are no longer in-force:</p> <p>_____</p>
<p>5. UNDERWRITING: I have reviewed the underwriting guidelines and the information provided in this application. The following risk class was quoted to the Applicant: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard</p>	<p>5. UNDERWRITING: I have reviewed the underwriting guidelines and the information provided in this application. The following risk class was quoted to the Applicant: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard</p>
<p>6. APS ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name: _____ Date Ordered: _____ (MM/DD/YY) Vendor Used: _____</p>	<p>6. APS ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name: _____ Date Ordered: _____ (MM/DD/YY) Vendor Used: _____</p>
<p>7. Is this a replacement policy? (If yes, provide Replacement Notice) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7. Is this a replacement policy? (If yes, provide Replacement Notice) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>8. Modal Premium \$ _____ Annualized Premium \$ _____ (continued)</p>	<p>8. Modal Premium \$ _____ Annualized Premium \$ _____ (continued)</p>

MAIL THIS PAGE TO METLIFE

AGENT'S REPORT (CONTINUED)

9. CERTIFICATION:

- 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 (were) 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 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.



Signature of Licensed & Appointed Agent

Name of Licensed & Appointed Agent (Please Print)

Offered through:* MLFS NEF GenAm MLR General Agent Other _____
(other than GenAm) Firm Name

Office ID# _____ Producer # _____ SS# _____

Street Address _____ Apt. # _____ City/State/Zip _____

Phone/Fax _____ e-mail address _____

10. For split commission cases, provide the information requested below, indicating the percentage of commission applicable to each:

	Print Name	Agency#/ Firm Name	Producer #	SS#	Percent	Distribution Channel *
1 st Rep.						<input type="checkbox"/> MLFS <input type="checkbox"/> NEF <input type="checkbox"/> GenAm <input type="checkbox"/> MLR <input type="checkbox"/> General Agent <input type="checkbox"/> Other
2 nd Rep.						<input type="checkbox"/> MLFS <input type="checkbox"/> NEF <input type="checkbox"/> GenAm <input type="checkbox"/> MLR <input type="checkbox"/> General Agent <input type="checkbox"/> Other
3 rd Rep.						<input type="checkbox"/> MLFS <input type="checkbox"/> NEF <input type="checkbox"/> GenAm <input type="checkbox"/> MLR <input type="checkbox"/> General Agent <input type="checkbox"/> Other

*Please select the appropriate box based on the distribution channel you are submitting business under:
MLFS...MetLife Financial Services **NEF**...New England Financial **GenAm**...General American
MLR...MetLife Resources **General Agent**...LTC Brokerage **Other:** _____

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

MGA Name _____ MGA Code _____ MGA Address _____

MGA Phone # _____ Fax # _____

MGA contact (for application status) _____ e-mail (for application status) _____

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

AGA _____
 GA1 _____
 Broker _____

IF SPLIT

AGA _____
 GA1 _____
 Broker _____

Enter "pending" if code not yet assigned.

SIGN & MAIL THIS PAGE TO METLIFE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

CONDITIONAL PREMIUM RECEIPT

APPLICANT 1

Received from

Name of Applicant 1 (Please print)

\$ on

Amount

Date

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

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

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

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

1. Completion of the application, in which you have answered “No” to all Questions in Part B 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 Part B of 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 60 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, 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.

SIGN & MAIL THIS PAGE TO METLIFE

CONDITIONAL PREMIUM RECEIPT (CONTINUED)

APPLICANT 1

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of 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 Part B of 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.



Signature of Applicant 1

Date

No agent 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 B of your application.

Receipt of \$ is acknowledged from

in connection with the application for Long-Term Care Insurance on this date By:



Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Vice-President and Secretary

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 OR LEAVE THE PAYEE BLANK.**

SIGN & MAIL THIS PAGE TO METLIFE

CONDITIONAL PREMIUM RECEIPT (CONTINUED)

APPLICANT 1

Received from
Name of Applicant 1 (Please print)

\$ on
Amount Date

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

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

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

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

1. Completion of the application, in which you have answered “No” to all Questions in Part B 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 Part B of 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 60 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, 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.

SIGN & LEAVE THIS PAGE WITH APPLICANT

CONDITIONAL PREMIUM RECEIPT (CONTINUED)

APPLICANT 1

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of 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 Part B of 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.



Signature of Applicant 1

Date

No agent 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 B of your application.

Receipt of \$ is acknowledged from

in connection with the application for Long-Term Care Insurance on this date By:



Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Vice-President and Secretary

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 OR LEAVE THE PAYEE BLANK.**

SIGN & LEAVE THIS PAGE WITH APPLICANT

CONDITIONAL PREMIUM RECEIPT

APPLICANT 2

Received from
 Name of Applicant 2 (Please print)
 \$ on
 Amount Date

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

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

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

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

1. Completion of the application, in which you have answered “No” to all Questions in Part B 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 Part B of 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 60 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, 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.

SIGN & MAIL THIS PAGE TO METLIFE

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of 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 Part B of 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.



Signature of Applicant 2

Date

No agent 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 B of your application.

Receipt of \$ is acknowledged from

in connection with the application for Long-Term Care Insurance on this date By:



Signature of Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Vice-President and Secretary

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 OR LEAVE THE PAYEE BLANK.**

SIGN & MAIL THIS PAGE TO METLIFE

CONDITIONAL PREMIUM RECEIPT (CONTINUED)

APPLICANT 2

Received from
Name of Applicant 2 (Please print)

\$ on
Amount Date

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

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

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

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

1. Completion of the application, in which you have answered “No” to all Questions in Part B 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 Part B of 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 60 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, 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.

SIGN & LEAVE THIS PAGE WITH APPLICANT

CONDITIONAL PREMIUM RECEIPT (CONTINUED)

APPLICANT 2

I have read this Conditional Premium Receipt, and reviewed my answers to all Questions in Part B of 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 Part B of 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.



Signature of Applicant 2

Date

No agent 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 B of your application.

Receipt of \$ is acknowledged from

in connection with the application for Long-Term Care Insurance on this date By:



Signature of Authorized Agent

Metropolitan Life Insurance Company

Gwenn L. Carr

Vice-President and Secretary

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 OR LEAVE THE PAYEE BLANK.**

SIGN & LEAVE THIS PAGE WITH APPLICANT

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 1

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; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife's behalf in this regard:


- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

 <p>_____ Applicant 1 Name (print)</p> <p>_____ Signature of Applicant 1</p>	<p>_____ Date of Birth</p> <p>_____ Date</p>
--	--

SIGN & MAIL THIS PAGE TO METLIFE

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 2

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; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife's behalf in this regard:


- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

 <p>_____ Applicant 2 Name (print)</p> <p>_____ Signature of Applicant 2</p>	<p>_____ Date of Birth</p> <p>_____ Date</p>
---	--

SIGN & MAIL THIS PAGE TO METLIFE

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 1

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; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife's behalf in this regard:


- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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

	_____	_____
	Applicant 1 Name (print)	Date of Birth
_____	_____	
Signature of Applicant 1	Date	

SIGN & LEAVE THIS PAGE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK.

AUTHORIZATION TO RELEASE INFORMATION TO METLIFE

APPLICANT 2

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; any insurer; employer; group policyholder, contract holder, or benefit plan administrator to give Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife's behalf in this regard:

- personal information and data about me;
- the entire medical file for the last three years, including medical information, records and data, about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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 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 without my authorization as permitted by applicable law.
- 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 about me, including medical information, records and data, may be disclosed to the California Department of Health or other health oversight agency and to other parties without my authorization, as required or otherwise permitted by applicable law.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

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



Applicant 2 Name (print)

Date of Birth

Signature of Applicant 2

Date

SIGN & LEAVE THIS PAGE WITH APPLICANT

THIS PAGE IS INTENTIONALLY LEFT BLANK.

CONSUMER PRIVACY NOTICE

APPLICANT 1

Metropolitan Life Insurance Company

If you submit a request for insurance (application or enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company (MetLife).

Please Read This Privacy Notice Carefully. It describes how we learn about you and how we treat the information we collect about you. (If anyone else is to be insured under the coverage you request, what we say here also applies to information about them.)

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, health care providers and others. The Authorization that you sign when you applied for insurance permits these sources to tell us about you. So we may, for instance, at our expense:

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

How We Protect What We Know: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Tell a group customer about its members' claims or cooperating in a group customer's audit of our service

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for

LEAVE THIS PAGE WITH APPLICANT

CONSUMER PRIVACY NOTICE (CONTINUED)

APPLICANT 1

- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy

Generally, we will disclose only the information we consider reasonably necessary to disclose.

How We Use and Disclose What We Know About You to Offer You Other Products and Services:

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") PROTECTS YOUR INFORMATION IF YOU REQUEST OR PURCHASE LONG-TERM CARE INSURANCE FROM US. IN ADDITION TO THE LIMITATIONS DESCRIBED IN THIS SECTION "**HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU TO OFFER YOU OTHER PRODUCTS AND SERVICES,**" HIPAA FURTHER LIMITS OUR ABILITY TO USE AND DISCLOSE THE INFORMATION THAT WE OBTAIN AS A RESULT OF YOUR REQUEST OR PURCHASE OF LONG-TERM CARE INSURANCE. INFORMATION ABOUT YOUR RIGHTS UNDER HIPAA WILL BE PROVIDED TO YOU WITH ANY LONG-TERM CARE COVERAGE ISSUED TO YOU. FOR MORE INFORMATION SEE THE LAST PARAGRAPH OF THIS NOTICE.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information):

- to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.
- to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you.
- to other financial services companies, if we have joint marketing agreements with them so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company.

You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: This is a general description of MetLife's information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. For example, individuals who request or purchase Long-Term Care Insurance coverage from us have rights under HIPAA. For additional information about your rights under HIPAA, or, for other information about privacy please contact us at our website, www.metlife.com, or write to MetLife, P.O. Box 937, Westport, Connecticut 06881-0937.

MetLife®

Metropolitan Life Insurance Company
New York, NY 10166

LEAVE THIS PAGE WITH APPLICANT

CONSUMER PRIVACY NOTICE

APPLICANT 2

Metropolitan Life Insurance Company

If you submit a request for insurance (application or enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of Metropolitan Life Insurance Company (MetLife).

Please Read This Privacy Notice Carefully. It describes how we learn about you and how we treat the information we collect about you. (If anyone else is to be insured under the coverage you request, what we say here also applies to information about them.)

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies.

How We Get Information: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, health care providers and others. The Authorization that you sign when you applied for insurance permits these sources to tell us about you. So we may, for instance, at our expense:

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

How We Protect What We Know: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business
- Tell a group customer about its members' claims or cooperating in a group customer's audit of our service

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for

LEAVE THIS PAGE WITH APPLICANT

CONSUMER PRIVACY NOTICE (CONTINUED)

APPLICANT 2

- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your policy

Generally, we will disclose only the information we consider reasonably necessary to disclose.

How We Use and Disclose What We Know About You to Offer You Other Products and Services:

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") PROTECTS YOUR INFORMATION IF YOU REQUEST OR PURCHASE LONG-TERM CARE INSURANCE FROM US. IN ADDITION TO THE LIMITATIONS DESCRIBED IN THIS SECTION "**HOW WE USE AND DISCLOSE WHAT WE KNOW ABOUT YOU TO OFFER YOU OTHER PRODUCTS AND SERVICES,**" HIPAA FURTHER LIMITS OUR ABILITY TO USE AND DISCLOSE THE INFORMATION THAT WE OBTAIN AS A RESULT OF YOUR REQUEST OR PURCHASE OF LONG-TERM CARE INSURANCE. INFORMATION ABOUT YOUR RIGHTS UNDER HIPAA WILL BE PROVIDED TO YOU WITH ANY LONG-TERM CARE COVERAGE ISSUED TO YOU. FOR MORE INFORMATION SEE THE LAST PARAGRAPH OF THIS NOTICE.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information):

- to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.
- to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you.
- to other financial services companies, if we have joint marketing agreements with them so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company.

You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: This is a general description of MetLife's information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. For example, individuals who request or purchase Long-Term Care Insurance coverage from us have rights under HIPAA. For additional information about your rights under HIPAA, or, for other information about privacy please contact us at our website, www.metlife.com, or write to MetLife, P.O. Box 937, Westport, Connecticut 06881-0937.

MetLife®

Metropolitan Life Insurance Company
New York, NY 10166

LEAVE THIS PAGE WITH APPLICANT

Complete this page for REPLACEMENT POLICIES only



APPLICANT 1

If Part F, 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 (LTC) 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: (Use additional sheets as necessary.) I have reviewed your current medical, health, and LTC 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 LTC insurance coverage, you may wish to secure the advice of your present insurer or its agent 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.

	
	Signature of Sales Representative, Agent or Broker
Print Name and Address of Sales Representative, Agent or Broker	
The above "Notice to Applicant" was delivered to me on: Date	
	
	Signature of Applicant 1

SIGN & LEAVE THIS PAGE WITH APPLICANT

Complete this page for REPLACEMENT POLICIES only



APPLICANT 1

If Part F, 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 (LTC) 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: (Use additional sheets as necessary.) I have reviewed your current medical, health, and LTC 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 LTC insurance coverage, you may wish to secure the advice of your present insurer or its agent 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.

	
	Signature of Sales Representative, Agent or Broker
Print Name and Address of Sales Representative, Agent or Broker	
The above "Notice to Applicant" was delivered to me on: Date	
	
	Signature of Applicant 1

SIGN & MAIL THIS PAGE TO METLIFE

AGENT DETACH HERE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

Complete this page for REPLACEMENT POLICIES only

APPLICANT 2

If Part F, 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 (LTC) 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: (Use additional sheets as necessary.) I have reviewed your current medical, health, and LTC 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 LTC insurance coverage, you may wish to secure the advice of your present insurer or its agent 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.

AGENT DETACH HERE

SIGN _____
Signature of Sales Representative, Agent or Broker

Print Name and Address of Sales Representative, Agent or Broker

The above "Notice to Applicant" was delivered to me on: _____ Date

SIGN _____
Signature of Applicant 2

SIGN & LEAVE THIS PAGE WITH APPLICANT

Complete this page for REPLACEMENT POLICIES only

APPLICANT 2

If Part F, 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 (LTC) 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: (Use additional sheets as necessary.) I have reviewed your current medical, health, and LTC 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 LTC insurance coverage, you may wish to secure the advice of your present insurer or its agent 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.

SIGN _____
Signature of Sales Representative, Agent or Broker

Print Name and Address of Sales Representative, Agent or Broker

The above "Notice to Applicant" was delivered to me on: _____ Date

SIGN _____
Signature of Applicant 2

SIGN & MAIL THIS PAGE TO METLIFE

THIS PAGE IS INTENTIONALLY LEFT BLANK.

THIS PAGE IS INTENTIONALLY LEFT BLANK.

LTC BENEFICIARY DESIGNATION FORM (CONTINUED)

APPLICANT 1

If no beneficiary designated shall be living following the insured's death or is otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary shall be paid to the insured's estate. If more than one beneficiary is selected, and one or more, but not all of such beneficiaries are deceased at the time of the insured's death or otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary(ies) shall be paid to 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).

If MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the time of the insured's death, I hereby designate my estate as beneficiary.

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 for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate my estate as beneficiary.

I understand and agree that any payment made in good faith by MetLife to the legal representative of my estate, pursuant to my designation of a beneficiary choice on this form shall be full discharge of the liability of MetLife with respect to the Return of Premium Rider under the Policy. Further I understand that the refund of premiums on death is not assignable, cannot be pledged or used as collateral for a loan etc; and any beneficiary designation I make is revocable by me prior to my death, but only by completing a MetLife “Beneficiary Designation Change Request Form” available by calling our Customer Service line at (888) 565-3761.

Print Name



Signature

Date

Please return this form to:

MetLife®

PO Box 5714
Hopkins MN 55343-4796

SIGN & MAIL THIS FORM TO METLIFE

LTC BENEFICIARY DESIGNATION FORM (CONTINUED)

APPLICANT 2

If no beneficiary designated shall be living following the insured's death or is otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary shall be paid to the insured's estate. If more than one beneficiary is selected, and one or more, but not all of such beneficiaries are deceased at the time of the insured's death or otherwise not able to receive the amount payable (e.g. minor), the amount that would have been payable to such beneficiary(ies) shall be paid to 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).

If MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the time of the insured's death, I hereby designate my estate as beneficiary.

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 for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate my estate as beneficiary.

I understand and agree that any payment made in good faith by MetLife to the legal representative of my estate, pursuant to my designation of a beneficiary choice on this form shall be full discharge of the liability of MetLife with respect to the Return of Premium Rider under the Policy. Further I understand that the refund of premiums on death is not assignable, cannot be pledged or used as collateral for a loan etc; and any beneficiary designation I make is revocable by me prior to my death, but only by completing a MetLife “Beneficiary Designation Change Request Form” available by calling our Customer Service line at (888) 565-3761.

Print Name



Signature

Date

Please return this form to:

MetLife®
PO Box 5714
Hopkins MN 55343-4796

SIGN & MAIL THIS FORM TO METLIFE

LONG-TERM CARE INSURANCE REPLACEMENT CHECKLIST (CONTINUED)

APPLICANT 1

REPLACEMENT CHECKLIST

Instructions for Comparison & Scoring:

Complete All Questions – Respond on Page 48, Total Score, Complete Applicant & Producer Information, Return Form with Application.

1. Indicate the Policy Coverages: Home Health Care OR Nursing Facility OR Comprehensive (Both Nursing Facility & Home Health Care)

Score: Comprehensive is GREATER than Nursing Home which is GREATER than Home Health Care

- If MetLife’s Coverage is > Existing Policy Coverage,-----then score = **+1**
- If MetLife’s Coverage is = Existing Policy Coverage,-----then score = **0**
- If MetLife’s Coverage is < Existing Policy Coverage,-----then score = **-1**

If both policies provide comprehensive coverage, then complete #2, if not, skip to #3.

2. Home Health Care Percentage (HHC%) – Indicate Amount of Home Health Care as a percentage of Nursing Facility Daily Benefit Amount (DBA)

Score: HIGHER percentage provides more coverage

- If MetLife’s Policy HHC% is > Existing Policy Coverage HHC%,-----then score = **+1**
- If MetLife’s Policy HHC% home care DBA is = Existing Policy Coverage HHC%,-----then score = **0**
- If MetLife’s Policy HHC% home care DBA is < Existing Policy Coverage HHC%,-----then score = **-1**

3. Total Lifetime Duration – Indicate total policy duration: Number of years (e.g., 2 years, 3 years, etc.)

Score: A LONGER duration provides more coverage

- If MetLife’s Policy Duration is > Existing Policy Duration,-----then score = **+1**
- If MetLife’s Policy Duration is = Existing Policy Duration,-----then score = **0**
- If MetLife’s Policy Duration is < Existing Policy Duration,-----then score = **-1**

4. Inflation Option – Determine Inflation Protection Under Policy

Score: Compound Inflation provides more inflation protection than Simple, Optional or None

Simple Inflation provides more inflation protection than Optional or No Inflation Protection

Optional Inflation provides more inflation protection than No Inflation Protection

- If MetLife’s Policy Inflation Protection is > Existing Policy Inflation Protection,-----then score = **+1**
- If MetLife’s Policy Inflation Protection is = Existing Policy Inflation Protection,-----then score = **0**
- If MetLife’s Policy Inflation Protection is , Existing Policy Inflation Protection,-----then score = **-1**

Complete This Section:

ANNUAL PREMIUM:

Existing Policy \$ _____ Replacement Policy \$ _____ Difference \$ _____

SIGN & MAIL THIS FORM TO METLIFE

LONG-TERM CARE INSURANCE REPLACEMENT CHECKLIST

APPLICANT 2

COMPLETE FOR REPLACEMENTS INVOLVING METLIFE LONG-TERM CARE INSURANCE
 To be completed by Producer & Submitted with Application

Features:	Existing Policy: Company:	Proposed Replacement MetLife Individual Business	Score
1. Nursing Facility or Comprehensive or Home Health Care			
2. Home Health Care Percent of Nursing Facility Daily Benefit Amount (DBA)			
3. Policy Duration			
4. Inflation Protection			
TOTAL SCORE			

CHECK ONE:

- IF VALUE OF SCORE IS A POSITIVE NUMBER (+), then the benefits of the MetLife Replacement Policy may be considered Better or Greater than the benefits of the Existing Policy
- If Value of score is ZERO (0) or is a NEGATIVE NUMBER (-), then the benefits of the MetLife Replacement Policy may not be considered Better or Greater than the benefits of the Existing Policy.

To be completed by Applicant:

I have reviewed this form with my producer.

Signature of Applicant

Name of Applicant (Please Print)

Street Address

City

State

Zip

To be completed by Licensed and Appointed

Producer: I certify that each question was asked of the applicant and answered as recorded.

Signature of Licensed and Appointed Producer

Name of Licensed and Appointed Producer (Please Print)

Phone

Fax

Street Address

City

State

Zip

(over please)

MAIL THIS FORM TO METLIFE

LONG-TERM CARE INSURANCE REPLACEMENT CHECKLIST (CONTINUED)

APPLICANT 2

REPLACEMENT CHECKLIST

Instructions for Comparison & Scoring:

Complete All Questions – Respond on Page 48, Total Score, Complete Applicant & Producer Information, Return Form with Application.

1. Indicate the Policy Coverages: Home Health Care OR Nursing Facility OR Comprehensive (Both Nursing Facility & Home Health Care)

Score: Comprehensive is GREATER than Nursing Home which is GREATER than Home Health Care

- If MetLife’s Coverage is > Existing Policy Coverage,-----then score = **+1**
- If MetLife’s Coverage is = Existing Policy Coverage,-----then score = **0**
- If MetLife’s Coverage is < Existing Policy Coverage,-----then score = **-1**

If both policies provide comprehensive coverage, then complete #2, if not, skip to #3.

2. Home Health Care Percentage (HHC%) – Indicate Amount of Home Health Care as a percentage of Nursing Facility Daily Benefit Amount (DBA)

Score: HIGHER percentage provides more coverage

- If MetLife’s Policy HHC% is > Existing Policy Coverage HHC%,-----then score = **+1**
- If MetLife’s Policy HHC% home care DBA is = Existing Policy Coverage HHC%,-----then score = **0**
- If MetLife’s Policy HHC% home care DBA is < Existing Policy Coverage HHC%,-----then score = **-1**

3. Total Lifetime Duration – Indicate total policy duration: Number of years (e.g., 2 years, 3 years, etc.)

Score: A LONGER duration provides more coverage

- If MetLife’s Policy Duration is > Existing Policy Duration,-----then score = **+1**
- If MetLife’s Policy Duration is = Existing Policy Duration,-----then score = **0**
- If MetLife’s Policy Duration is < Existing Policy Duration,-----then score = **-1**

4. Inflation Option – Determine Inflation Protection Under Policy

Score: Compound Inflation provides more inflation protection than Simple, Optional or None

Simple Inflation provides more inflation protection than Optional or No Inflation Protection

Optional Inflation provides more inflation protection than No Inflation Protection

- If MetLife’s Policy Inflation Protection is > Existing Policy Inflation Protection,-----then score = **+1**
- If MetLife’s Policy Inflation Protection is = Existing Policy Inflation Protection,-----then score = **0**
- If MetLife’s Policy Inflation Protection is , Existing Policy Inflation Protection,-----then score = **-1**

Complete This Section:

ANNUAL PREMIUM:

Existing Policy \$ _____ Replacement Policy \$ _____ Difference \$ _____

SIGN & MAIL THIS FORM TO METLIFE

APPLICATION SUBMISSION CHECKLIST

AGENT

Please make sure the following are correct:

- Personal Worksheet is completed (in required states).
If the applicant chooses not to complete the Personal Worksheet, please complete the *Authorization to Proceed Processing Application Form*.
- Only individual applicants complete this application.
Multi-Life program group applicants require different applications.
- Correct distribution channel is selected in Agent's Report.
- For Automatic Checking Account Deduction of premium, a voided check is included and Part E, Question 3 is completed and signed.
- All Health Information is complete.
- The *Authorization to Release Information* is signed by the applicant(s).
- All signatures boxes are complete.
- The Beneficiary Designation Form for the Return of Premium Rider should only be completed if the Applicant is selecting the Return of Premium Rider and chooses to designate a beneficiary other than their estate.

LOOK FOR:

APPLICANT(S)



Minimum of 4-10 signatures per applicant

LICENSED AND APPOINTED AGENT



Minimum of 3-7 signatures



INSURANCE MARKETPLACE
STANDARDS ASSOCIATION

have you met life today?®

LTC01614(1005) 0505-7946
© 2005 METLIFE, INC.
PEANUTS © United Feature Syndicate, Inc.

MetLife®

Metropolitan Life Insurance Company
New York, NY 10166
www.metlife.com