

Application to the Metropolitan Life Insurance Company

CSEA PREMIER TERM LIFE INSURANCE PLAN

Full Name: (Last, First, Initial) _____ Date of Birth: (mo) (day) (year) _____

Social Security No.: _____ Male Female

Height: _____ Weight: _____ Single, Widowed, Divorced Married

Home Address: _____

City: _____ State: _____ Zip: _____

Employed By: _____ State Local Government Private Sector

Occupation: _____ Date Employed: _____ (mo) (day) (year)

Home Phone #: () _____ Work Phone #: () _____ Ext. _____

Insurance Requested: Are you presently covered under this program? Yes No

Amount applied for \$ _____ (From \$10,000 to \$250,000)

Are you applying for an increase in coverage? Yes No Increase Amount \$ _____

Beneficiary: (Last, First, Initial) _____ Relationship: _____

Address of Beneficiary: _____

City: _____ State: _____ Zip: _____

COMPLETE ONLY IF APPLYING FOR DEPENDENTS COVERAGE

Spouse, or
 Domestic partner: _____
(Name if proposed for insurance)

Date of Birth: (mo) (day) (year) _____ Height: _____ Weight: _____

Is the CSEA member's spouse/domestic partner presently covered under this program? Yes No
 Is this an increase? Yes No

Amount applied for \$ _____ (From \$10,000 to \$150,000 - but not more than member's amount)

Increase Amount \$ _____ Spouse/Domestic partner's Social Security #: _____

Child(ren) Amount: \$5,000 \$10,000 (\$500 for child age 15 days to 6 months)

Child Name	Date of Birth (mo) (day) (year)	Child Name	Date of Birth (mo) (day) (year)

The CSEA member will be the beneficiary for spouse/domestic partner and dependent children insurance.

STATEMENT OF HEALTH

- a. Are all persons to be insured, other than homemakers and students, actively at work, performing all duties of a regular occupation at a customary place of employment? Yes No
- b. Is any proposed insured now taking any prescribed medication or receiving any medical treatment? Yes No
- c. Has any person proposed for insurance ever had: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, tuberculosis, liver disorder (including hepatitis), asthma or emphysema, enlarged lymph nodes or immunodeficiency disorder, albumin or blood or sugar in urine, back trouble/ disorder, unexplained weight loss, other illness, disease or injury? Yes No
- d. During the past five years has any person proposed for insurance been counselled or treated by a physician or hospitalized for the use of alcohol or drugs? Yes No

Application continues on other side

AUTHORIZATION (this form must be signed on reverse side and returned with application)

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse/domestic partner, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about the proposed insured;
- medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
- information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about the proposed insured relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
- information, records and data about the proposed insured relating to mental illness, except 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. Unless permitted by applicable law, the proposed insured 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 the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at 4100 Boy Scout Blvd, Tampa, FL 33607 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.

STATEMENT OF HEALTH (con't)

- e. During the past five years has any person proposed for insurance consulted any physician or medical care practitioner other than for a routine physical examination or checkup, or been confined or treated in any hospital, rest home or similar institution? Yes No
- f. If a consultation with a physician was for a routine or annual examination, were there any symptoms or adverse findings? Yes No
- g. Have you or any eligible dependent ever been diagnosed by or received medical treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

IF ANY ANSWER TO ITEMS (a.) is no, and (b. - g.) is yes, GIVE NAMES, DATES AND FULL DETAILS HERE. (If you need more space, use a separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous".)

Question	Person to whom it applies	Date of Treatment	Date of Recovery	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results	Name of Treating Physician or Other Practitioner or Name of Clinic or Hospital. Include complete address and telephone number

- I am a member of Civil Service Employees Association, Inc. and I certify that: (A) I am actively at work at the time of application and (B) that I personally designated the Beneficiary and the date of birth shown hereon.
- I apply herewith for membership in Civil Service Employees Association, Inc. and I certify that: (A) I am actively at work at the time of application and (B) that I personally designated the Beneficiary and the date of birth shown hereon.

ACKNOWLEDGMENT AND AUTHORIZATION

Each person signing below declares that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

Proposed Insured's Signature: X _____ **Date:** _____

Spouse's or Domestic Partner's Signature: X _____ **Date:** _____
 (if applying for coverage)

Metropolitan Life Insurance Company, New York, NY 10010

For the Accelerated Benefits Option:

I understand that my Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her Life Insurance amount.
 I also understand that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment and that accelerated benefits may be taxable.

Fraud Warning:

Residents of New York and all applicants please note [only applies to Accidental Death and Dismemberment Benefits]: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Residents of New Jersey please note: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Residents of all other states please note: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

L10081603 (exp1010) (CT,NJ,NY,PA)

Agent# _____

- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

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

PLEASE BE SURE TO SIGN BELOW AND RETURN WITH YOUR APPLICATION

Print Name of Employee	Signature of Employee	Date (Mo./Day/Yr.)
Print Name of Employee's Spouse/Domestic partner	Signature of Employee's Spouse/Domestic partner	Date (Mo./Day/Yr.)
Print Name of Child # 1	Signature of Child # 1 or Signature & relationship of Personal Representative*	Date (Mo./Day/Yr.)
Print Name of Child # 2	Signature of Child # 2 or Signature & relationship of Personal Representative*	Date (Mo./Day/Yr.)

*If the child is under age 18, a Personal Representative for the child must sign, and indicate the legal relationship between the Personal Representative and the proposed insured. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.