MetLife®
Metropolitan Life Insurance Company, New York, NY

Group Specified Disease Insurance Enrollment Form

For Research Foundation — Group Report No. 0117655

Section To Be Completed By Employee

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female
Address Street City State Zip Code		Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-Mail Address		Phone No. (include area code)	
Employee ID No.	State/Country of Birth		

If requesting Dependent coverage (Spouse, Domestic Partner* and Child), complete section below:

	Name (Last, First, MI)	Date of Birth	Sex (M/F)	Social Security No.
Domestic Partner/ Spouse:				
Child(ren):				

Is this coverage for a domestic partner? ☐ Yes ☐ No

*Additional information is required for Domestic Partner Coverage. Please contact MetLife at 1 800 GET-MET 8.

COVERAGE REQUEST DATA:

I have received and read a copy of the outline of coverage for the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below. I understand that no person will be covered until they are accepted for coverage by MetLife. **I request the following coverage:**

Employee Coverage (you must enroll for Employee Coverage to be eligible for Dependent Spouse, Domestic Partner or Dependent Child Coverage)	**Dependent Spouse or Domestic Partner Coverage** (cannot exceed employee amount)	**Dependent Child Coverage**
☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ No Coverage	☐ $5,000 ☐ No Coverage

	Employee	Spouse/Domestic Partner
Have you smoked cigarettes, or used any other tobacco or nicotine product within the 12 months preceding the date of this enrollment form?	☐ Yes ☐ No	☐ Yes ☐ No

	Employee	Spouse/Domestic Partner	Child(ren)
For all persons to be insured, is there medical coverage in force providing benefits for hospital, surgical and medical expenses or hospital, surgical and medical treatment under or through an employer's plan of self-insurance, health maintenance organization contract, group or individual medical insurance policy or Medicare?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

	Employee	Spouse/Domestic Partner	Child(ren)
Are you, your spouse or dependent children currently covered under any other critical illness or specified disease policy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If yes, please list who is covered and the conditions covered under other policy(ies).

_____

_____

PLEASE RETAIN A COPY OF THE FULLY COMPLETED FORM FOR YOUR RECORDS; RETURN ORIGINAL TO:
METLIFE CRITICAL ILLNESS INSURANCE, PO BOX 14250, LEXINGTON, KY 40512-4250
IF YOU HAVE ANY QUESTIONS, CALL METLIFE AT 1 800 GET-MET 8 (1-800-438-6388)

Medical Information

Please complete all questions below. Omitted information will cause delays. Please note that there is space at the end to give full details. If more space is needed for full details, attach a separate sheet, sign and date it. "You" and "Your" refers to the employee for whom insurance is requested. If the employee is requesting coverage for a domestic partner, please provide information regarding the domestic partner in the spaces provided for "Spouse".

1. Your: Height _____ feet _____ inches Weight _____ lbs.
2. Your spouse/domestic partner's: Height _____ feet _____ inches Weight _____ lbs.

	Employee	Domestic Partner/ Spouse	Any Child(ren)
3. Have you been hospitalized* (see the definition at the end of these questions) during the 24 months preceding the date of this enrollment form for any reason other than pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. On the date of this application are you receiving or applying for any disability benefits or confined at home under the care of a physician due to a sickness or injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever had an organ transplant, been told by a physician or other health care provider that you require an organ transplant, or are you presently on a list for organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you ever been diagnosed, treated, or given medical advice by a physician or other health care provider for:			
a. heart attack, chest pain, or heart trouble?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. cancer, tumors, Hodgkin's Disease, leukemia or other blood disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c. stroke or other neurological disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d. blood clots or other circulatory disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. high cholesterol or high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f. diabetes, impaired glucose tolerance, or high blood sugar?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g. prostate trouble or an elevated prostate specific antigen ("PSA") test result?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h. chronic hepatitis B (including if a carrier), hepatitis C, cirrhosis or other liver disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i. kidney disease or disorder other than kidney stones?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you ever been diagnosed or treated by a member of the medical profession for Human Immuno-deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Give full details for "Yes" answers. (additional space is provided below, if needed)

Question Number	Details
6e	(If you answered "Yes" to question 6e, please provide most recent: Cholesterol results: _____/_____ Date: _____ Blood Pressure Results: _____/_____ Date: _____)

8. Are you actively at work on a full-time basis performing all of the usual and customary duties of your job at the employer's place of business or an alternative place approved by the employer? **Employee** ☐ Yes ☐ No

*"Hospitalized" means admission for inpatient care in a hospital; receipt of care in a hospice facility, an intermediate care facility or a long term care facility; or receipt of the following treatment wherever performed: chemotherapy; radiation therapy; or dialysis.

Use the space below to provide additional information for any of the above answers.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)				
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife Critical Illness Insurance payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.				
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Percentage	Date of Birth (Mo./Day/Year)	Address (Street, City, State, Zip)

DECLARATION SECTION

The employee **declares** that he or she is actively at work on the date of this enrollment form. In addition if the employee is not actively at work on the scheduled Effective Date of the insurance requested, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or hospitalized. "Hospitalized" means admission for inpatient care in a hospital; receipt of care in a hospice facility, an intermediate care facility or a long term care facility; or receipt of the following treatment wherever performed: chemotherapy; radiation therapy; or dialysis. MetLife does not charge premium on account of any person during time periods when such person is not insured.

For Changes Requested After Initial Enrollment Period Expires

I understand that if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

For Payroll Deduction Authorization By the Employee

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

Florida: **Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

Massachusetts: **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, and may subject such person to criminal and civil penalties.**

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

New York: **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.**

Oklahoma: **Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

Kansas and Oregon: **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.**

Virginia: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

In any other case, read the following warning.

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

Signature(s): The employee must sign in all cases. 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. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature	Print Name	Date (Mo./Day/Yr.)
Other Proposed Insured Signature	Print Name	Date (Mo./Day/Yr.)

Metropolitan Life Insurance Company
New York, New York 10166

AUTHORIZATION

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insured(s) (proposed insureds refers to the "employee", his or her spouse, 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 MIB Group, 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, information about the proposed insured(s), including:
  - personal information and data;
  - the entire medical file, including medical information, records and data, as well as information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data 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 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 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, a 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, a proposed insured may revoke this authorization at any time as it pertains to the release of information regarding such proposed insured. To revoke his or her authorization, a proposed insured must write to MetLife at MetLife Critical Illness, PO Box 14250, Lexington, KY 40512-4250, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives a 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.
- 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 pursuant to this Authorization, 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.

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

If signed by Personal Representative of Child, print name and describe relationship or authority:

Print Name of Child # 2	Signature of Child # 2 or Signature of Personal Representative*	Date (Mo./Day/Yr.)

If signed by Personal Representative of Child, print name and describe relationship or authority:

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. 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 or the authority that gives the individual the right to sign on behalf of the child.** 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.