

SERFF Tracking Number: META-126162298 State: Arkansas  
Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 42473  
Company Tracking Number: W09-6 BW (LW)  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: Individual Long-Term Care Insurance Application Filing  
Project Name/Number: LSAAPP-IND/W09-6 BW

## Filing at a Glance

Company: Metropolitan Life Insurance Company.

Product Name: Individual Long-Term Care SERFF Tr Num: META-126162298 State: ArkansasLH  
Insurance Application Filing

TOI: LTC03I Individual Long Term Care

SERFF Status: Closed

State Tr Num: 42473

Sub-TOI: LTC03I.001 Qualified

Co Tr Num: W09-6 BW (LW)

State Status: Approved-Closed

Filing Type: Form

Co Status: In Progress

Reviewer(s): Marie Bennett

Authors: Sandra Bennett, Ruth  
Rivera, Linda Williams

Disposition Date: 07/09/2009

Date Submitted: 05/22/2009

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: LSAAPP-IND

Status of Filing in Domicile: Not Filed

Project Number: W09-6 BW

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 07/09/2009

Explanation for Other Group Market Type:

State Status Changed: 07/09/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

This is an Individual Long Term Care Insurance Application Filing. (Due to the length of the Cover Letter, we have attached the letter under the Supporting Documentation Schedule)

## Company and Contact

SERFF Tracking Number: META-126162298 State: Arkansas  
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 Project Name/Number: LSAAPP-IND/W09-6 BW

**Filing Contact Information**

Carolyn Roth, Director croth@metlife.com  
 MetLife (212) 578-2944 [Phone]  
 New York, NY 10036-6796 (212) 578-3874[FAX]

**Filing Company Information**

Metropolitan Life Insurance Company. CoCode: 65978 State of Domicile: New York  
 MetLife Group Code: -99 Company Type: Life  
 1095 Avenue of the Americas  
 New York, NY 10036-6796 Group Name: State ID Number:  
 (212) 578-2211 ext. [Phone] FEIN Number: 13-5581829  
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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: \$20.00 Per Application submitted for Approval.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company.	\$20.00	05/22/2009	28066137
Metropolitan Life Insurance Company.	\$240.00	06/22/2009	28720813

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	07/09/2009	07/09/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Harris Shearer	06/22/2009	06/22/2009	Linda Williams	06/22/2009	06/22/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
Amendment to Filing from Analyst	Supporting Document	Linda Williams	06/24/2009	06/24/2009

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## Disposition

Disposition Date: 07/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Supporting Document</b>	Family History Question with Health Questions	Approved	Yes
<b>Supporting Document</b>	NAIC Transmittal Document	Approved	Yes
<b>Supporting Document</b>	Cover Letter	Approved	Yes
<b>Supporting Document</b>	Amendment to Filing from Analyst	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Request Form	Approved	Yes
<b>Form</b>	Request Form	Approved	Yes
<b>Form</b>	Request Form	Approved	Yes
<b>Form</b>	Request Form	Approved	Yes
<b>Form</b>	Conditional Premium Receipt	Approved	Yes
<b>Form</b>	Personal Worksheet	Approved	Yes
<b>Form</b>	Rate Disclosure Form	Approved	Yes
<b>Form</b>	Rate Disclosure Form	Approved	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 06/22/2009  
Submitted Date 06/22/2009  
Respond By Date 07/22/2009

Dear Carolyn Roth,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Application (Form)
- Request Form (Form)
- Request Form (Form)
- Request Form (Form)
- Request Form (Form)
- Conditional Premium Receipt (Form)
- Personal Worksheet (Form)
- Rate Disclosure Form (Form)
- Rate Disclosure Form (Form)

Comment: ARKANSAS' FILING FEE IS \$20.00 PER FORM. AN ADDITIONAL FILING FEE OF \$240.00 IS REQUIRED TO COMPLETE THE FILING.

Please feel free to contact me if you have questions.

Sincerely,

Harris Shearer

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 06/22/2009  
Submitted Date 06/22/2009

SERFF Tracking Number: META-126162298 State: Arkansas  
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Project Name/Number: LSAAPP-IND/W09-6 BW

Dear Marie Bennett,

**Comments:**

Please see our response to your Objection Letter dated 6/22/09.

**Response 1**

Comments: We have submitted a request for the additional amount of \$240.00 via SERFF EFT.

**Related Objection 1**

Applies To:

- Application (Form)
- Request Form (Form)
- Request Form (Form)
- Request Form (Form)
- Request Form (Form)
- Conditional Premium Receipt (Form)
- Personal Worksheet (Form)
- Rate Disclosure Form (Form)
- Rate Disclosure Form (Form)

Comment:

ARKANSAS' FILING FEE IS \$20.00 PER FORM. AN ADDITIONAL FILING FEE OF \$240.00 IS REQUIRED TO COMPLETE THE FILING.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you. We hope this will allow you to proceed with the review of this filing.

Sincerely,

*SERFF Tracking Number:*      *META-126162298*                      *State:*                      *Arkansas*  
*Filing Company:*              *Metropolitan Life Insurance Company.*              *State Tracking Number:*      *42473*  
*Company Tracking Number:*      *W09-6 BW (LW)*  
*TOI:*                      *LTC03I Individual Long Term Care*              *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *Individual Long-Term Care Insurance Application Filing*  
*Project Name/Number:*      *LSAAPP-IND/W09-6 BW*  
**Linda Williams, Ruth Rivera, Sandra Bennett**

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**Amendment Letter**

Amendment Date:

Submitted Date: 06/24/2009

**Comments:**

Please see our Amendment letter to request the extension of use with previously approved forms.

Thank you for your attention to this request.

William Wilson  
(908) 253-2290

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: Amendment to Filing from Analyst**

Comment: Attached is an amendment to this filing from Analyst.

Amendment Note to Arkansas 2009-06-24.pdf

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## Form Schedule

**Lead Form Number:** LSAAPP-IND

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	LSAAPP-IND-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		52	LSAAPP-IND-AR-filing.pdf
Approved	LSAAPP-ML-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		52	LSAAPP-ML-AR-filing.pdf
Approved	VIP2APP-IND-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		52	VIP2APP-IND-AR-filing.pdf
Approved	VIP2APP-ML-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		52	VIP2APP-ML-AR-filing.pdf
Approved	REINST-AR	Application/ Enrollment Form	Application Enrollment Form	Initial		50	REINST-AR-filing.pdf
Approved	LSA-TAPP-IND	Other	Request Form	Initial		0	LSA TAPP Ind-filing.pdf
Approved	LSA-TAPP-ML	Other	Request Form	Initial		0	LSA TAPP ML-filing.pdf
Approved	VIP2-TAPP-IND	Other	Request Form	Initial		0	VIP2 TAPP Ind-filing.pdf
Approved	VIP2-TAPP-ML	Other	Request Form	Initial		0	VIP2 TAPP ML-filing.pdf
Approved	CPR10	Other	Conditional Premium Receipt	Initial		51	CPR10-filing.pdf
Approved	PW10	Other	Personal Worksheet	Initial		56	PW10-filing.pdf
Approved	L-PRD10-10PAY	Other	Rate Disclosure Form	Initial		51	L-PRD10-10PAY-filing.pdf
Approved	V-PRD10-10PAY	Other	Rate Disclosure Form	Initial		51	V-PRD10-10PAY-

*SERFF Tracking Number:*      *META-126162298*                      *State:*                      *Arkansas*  
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*TOI:*                      *LTC03I Individual Long Term Care*              *Sub-TOI:*                      *LTC03I.001 Qualified*  
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*Project Name/Number:*      *LSAAPP-IND/W09-6 BW*

filing.pdf



Agent/Producer Distribution Channel:  MetLife  NEF  MLR  General Agent/Producer  Other \_\_\_\_\_ (Firm Name)

**PART A PERSON(S) APPLYING FOR COVERAGE** (Each applicant must complete ALL information below.)

**APPLICANT A**

E New Business Policy # \_\_\_\_\_ [(ADG only)]

1.  Mr.  Mrs.  Ms.  Dr. (check one)

2. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_

3. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Preferred Contact Phone Number ( ) \_\_\_\_\_

Additional Phone Number ( ) \_\_\_\_\_

Best time to call  Morning  Afternoon  Evening

5. E-mail address \_\_\_\_\_

6. Gender  Male  Female

7. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

[Place of Birth \_\_\_\_\_ (State & Country)]

8. Height \_\_\_\_\_ Weight \_\_\_\_\_

9. [Social Security Number] \_\_\_\_\_

10. Marital Status  Single/Widowed/Divorced  
 Married  
 Domestic Partner\*

11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO

IF YES please identify and provide requested information.

Spouse or Domestic Partner\*  Household Member

Name \_\_\_\_\_

[Social Security Number] \_\_\_\_\_

12. This is a request for  New Coverage  
 Increase of Existing Coverage  
[ Exercise Life or DI GPO Rider]

**APPLICANT B**

Is APPLICANT A your

Spouse or Domestic Partner\*  Household Member

1.  Mr.  Mrs.  Ms.  Dr. (check one)

2. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_

3. Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Preferred Contact Phone Number ( ) \_\_\_\_\_

Additional Phone Number ( ) \_\_\_\_\_

Best time to call  Morning  Afternoon  Evening

5. E-mail address \_\_\_\_\_

6. Gender  Male  Female

7. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

[Place of Birth \_\_\_\_\_ (State & Country)]

8. Height \_\_\_\_\_ Weight \_\_\_\_\_

9. [Social Security Number] \_\_\_\_\_

10. Marital Status  Single/Widowed/Divorced  
 Married  
 Domestic Partner\*

11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO

IF YES please identify and provide requested information.

Spouse or Domestic Partner\*  Household Member

Name \_\_\_\_\_

[Social Security Number] \_\_\_\_\_

12. This is a request for  New Coverage  
 Increase of Existing Coverage  
[ Exercise Life or DI GPO Rider]

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

**PART B**

**COVERAGE SELECTIONS**

Select either Simple Advantage **OR** Custom Advantage

**Simple Advantage** (Only available to applicants age 61 and under.)

**STEP 1 – Select the Maximum Amount of Initial Coverage you want:** (Select one box)

This plan includes Guaranteed Purchase Option Rider.

**APPLICANT A**

**APPLICANT B**

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT					
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K
\$3K	<input type="checkbox"/>	-				
\$6K	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT					
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K
\$3K	<input type="checkbox"/>	-				
\$6K	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

**APPLICANT A**

**APPLICANT B**

- Shared Care Rider\*
- Nonforfeiture Coverage Rider
- Cash Benefit Rider

- [Shared Care Rider\*
- Nonforfeiture Coverage Rider
- [Cash Benefit Rider

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

**OR**

**Custom Advantage**

**STEP 1 – Select the Maximum Amount of Coverage you want:** (Select one box)

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT						
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K	\$1MM
\$3K	<input type="checkbox"/>	-	-				
\$6K	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
\$9K	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$12K	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15K	-	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT						
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K	\$1MM
\$3K	<input type="checkbox"/>	-	-				
\$6K	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
\$9K	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$12K	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15K	-	-	-	-	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2– Decide whether you want any of the [3] optional benefit riders:**

**APPLICANT A**

**APPLICANT B**

- Shared Care Rider\*
- Nonforfeiture Coverage Rider
- Cash Benefit Rider\*\*

- [Shared Care Rider\*
- Nonforfeiture Coverage Rider
- [Cash Benefit Rider\*\*

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]  
 [\*\*Not available with \$1MM Total Benefit Amount.]

**STEP 3 – Select a Benefit Increase option:** (Select one box)

**APPLICANT A**

**APPLICANT B**

- Future Purchase Rider
- 3% Automatic Compound Inflation Protection Rider
- 5% Automatic Compound Inflation Protection Rider
- I do not choose a Benefit Increase option.]

- [Future Purchase Rider
- [3% Automatic Compound Inflation Protection Rider
- 5% Automatic Compound Inflation Protection Rider
- [I do not choose a Benefit Increase option.

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

APPLICANT A		If you have any doubt about your answers, ask your doctor.	APPLICANT B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke <b>within the past [5 years]</b> , multiple strokes, stroke with residual impairment, Transient Ischemic Attack (TIA) <b>within the past [2 years]</b> , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

**Primary Care Physician (with most of your records)**

**APPLICANT A**

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

**APPLICANT B**

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

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

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

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

You are required to answer all the questions in this section. Missing information will result in underwriting delays.

**If you have any doubt about your answers, ask your doctor.**

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

APPLICANT A		1. Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for:	APPLICANT B		APPLICANT A			APPLICANT B	
YES	NO		YES	NO	YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack / angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus / Scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery / angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement / fractures / falls	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis / amputation / weakness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory / lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney / bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / brain condition(s) / head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor / imbalance / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Spine / back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Depression / anxiety / bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	3. <b>Within the past 12 months</b> , have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you <b>ever</b> resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	6. Have you <b>ever</b> had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>	

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

APPLICANT A							APPLICANT B		
YES	NO						YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	8. Did you answer <b>YES</b> to any question 1-7? <b>IF YES</b> provide details below for <b>each</b> question for <b>each</b> applicant (separately).					<input type="checkbox"/>	<input type="checkbox"/>	
		Select Applicant	Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)			Name of Treating Health Professional(s)
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
<input type="checkbox"/>	<input type="checkbox"/>	9. Have you taken any medications (excluding vitamins) or supplements <b>within the past 12 months</b> ? <b>IF YES</b> provide details below for <b>each</b> medication taken for <b>each</b> applicant (separately).					<input type="checkbox"/>	<input type="checkbox"/>	
		Select Applicant	Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
<input type="checkbox"/>	<input type="checkbox"/>	10. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) <b>within the past 2 years</b> ? <b>IF YES</b> indicate date of last use. <b>APPLICANT A</b> _____ mm/dd/yyyy   <b>APPLICANT B</b> _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	11. Do you consume alcoholic beverages? <b>APPLICANT A</b> How often? _____ How much? _____   <b>APPLICANT B</b> How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	12. Have you <b>ever</b> been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? <b>IF YES</b> indicate date of last treatment. <b>APPLICANT A</b> _____ mm/dd/yyyy   <b>APPLICANT B</b> _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had a weight gain or loss of 10 pounds or more <b>within the past 12 months</b> ? <b>IF YES</b> please specify: <b>APPLICANT A</b> Pounds lost _____ Pounds gained _____   <b>APPLICANT B</b> Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	14. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? <b>IF YES</b> , please describe. <b>APPLICANT A</b> <input type="checkbox"/> I am employed: Job/Title _____ Hours/ Week _____ <input type="checkbox"/> I participate in other activities: _____ Hours/ Week _____   <b>APPLICANT B</b> <input type="checkbox"/> I am employed: Job/Title _____ Hours/ Week _____ <input type="checkbox"/> I participate in other activities: _____ Hours/ Week _____					<input type="checkbox"/>	<input type="checkbox"/>	



PART F		PAYMENT SELECTIONS																					
APPLICANT A			APPLICANT B																				
<input type="checkbox"/> <input type="checkbox"/>	<p><b>[1. Choose only ONE Premium Payment Option:</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> Standard                             </td> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> Standard                             </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Ten Year Premium Payment Rider*                             </td> <td style="padding: 5px;"> <input type="checkbox"/> Ten Year Premium Payment Rider*                             </td> </tr> </table> <p style="text-align: center; font-size: small;">*Not available with Simple Advantage or the Future Purchase Rider.</p> <p style="font-size: x-small;">*If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.                              *If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]</p>		<input type="checkbox"/> Standard	<input type="checkbox"/> Standard	<input type="checkbox"/> Ten Year Premium Payment Rider*	<input type="checkbox"/> Ten Year Premium Payment Rider*	<input type="checkbox"/> <input type="checkbox"/>																
<input type="checkbox"/> Standard	<input type="checkbox"/> Standard																						
<input type="checkbox"/> Ten Year Premium Payment Rider*	<input type="checkbox"/> Ten Year Premium Payment Rider*																						
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p><b>2. Choose only ONE of the payment methods below.</b>                      Please note there is an additional cost if you pay premiums more frequently than annually.</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> Annual Direct Bill                             </td> <td style="width: 50%; padding: 5px;"> <input type="checkbox"/> Annual Direct Bill                             </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Semi-Annual Direct Bill                             </td> <td style="padding: 5px;"> <input type="checkbox"/> Semi-Annual Direct Bill                             </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Quarterly Direct Bill                             </td> <td style="padding: 5px;"> <input type="checkbox"/> Quarterly Direct Bill                             </td> </tr> <tr> <td style="padding: 5px;"> <input type="checkbox"/> Monthly Direct Bill]                             </td> <td style="padding: 5px;"> <input type="checkbox"/> Monthly Direct Bill                             </td> </tr> </table> <p><b>If you would like your bill sent to an address other than the address listed in Part A, please indicate below.</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"><b>APPLICANT A</b></td> <td style="width: 50%; padding: 5px;"><b>APPLICANT B</b></td> </tr> <tr> <td style="padding: 5px;">Name _____</td> <td style="padding: 5px;">Name _____</td> </tr> <tr> <td style="padding: 5px;">Address _____</td> <td style="padding: 5px;">Address _____</td> </tr> <tr> <td style="padding: 5px;">City _____</td> <td style="padding: 5px;">City _____</td> </tr> <tr> <td style="padding: 5px;">State _____ Zip _____</td> <td style="padding: 5px;">State _____ Zip _____</td> </tr> <tr> <td style="padding: 5px;">Phone Number ( ) _____</td> <td style="padding: 5px;">Phone Number ( ) _____</td> </tr> </table>		<input type="checkbox"/> Annual Direct Bill	<input type="checkbox"/> Annual Direct Bill	<input type="checkbox"/> Semi-Annual Direct Bill	<input type="checkbox"/> Semi-Annual Direct Bill	<input type="checkbox"/> Quarterly Direct Bill	<input type="checkbox"/> Quarterly Direct Bill	<input type="checkbox"/> Monthly Direct Bill]	<input type="checkbox"/> Monthly Direct Bill	<b>APPLICANT A</b>	<b>APPLICANT B</b>	Name _____	Name _____	Address _____	Address _____	City _____	City _____	State _____ Zip _____	State _____ Zip _____	Phone Number ( ) _____	Phone Number ( ) _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> Annual Direct Bill	<input type="checkbox"/> Annual Direct Bill																						
<input type="checkbox"/> Semi-Annual Direct Bill	<input type="checkbox"/> Semi-Annual Direct Bill																						
<input type="checkbox"/> Quarterly Direct Bill	<input type="checkbox"/> Quarterly Direct Bill																						
<input type="checkbox"/> Monthly Direct Bill]	<input type="checkbox"/> Monthly Direct Bill																						
<b>APPLICANT A</b>	<b>APPLICANT B</b>																						
Name _____	Name _____																						
Address _____	Address _____																						
City _____	City _____																						
State _____ Zip _____	State _____ Zip _____																						
Phone Number ( ) _____	Phone Number ( ) _____																						
<input type="checkbox"/>	<p><input type="checkbox"/> Monthly Automatic Checking Account Deduction   <input type="checkbox"/> Monthly Automatic Checking Account Deduction</p> <p><b>Electronic Payment Agreement Authorization</b>                      Your monthly premium will be deducted automatically from the bank or credit union checking account you request. <b>Enclose a voided blank check for the account you wish to use. DO NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.</b> If using a credit union account, please provide credit union phone number.  <b>APPLICANT A:</b> Credit Union Phone Number ( ) _____  <b>APPLICANT B:</b> Credit Union Phone Number ( ) _____</p> <p><b>I authorize:</b> (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.</p> <p><b>APPLICANT A:</b> By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <p><b>APPLICANT B:</b> By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <p><b>X</b> _____ Date _____                      Signature of Account Holder for <b>APPLICANT A</b></p> <p><b>X</b> _____ Date _____                      Signature of Account Holder for <b>APPLICANT B</b></p>		<input type="checkbox"/>																				



**PART G**

**AGREEMENT AND ACKNOWLEDGEMENT – *continued***

**Your signature below:** Confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected 5% Automatic Compound Inflation Protection Rider, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection Rider and your rejection of 5% Automatic Compound Inflation Protection Rider.

**Caution:** If your answers or statements on this application are misstated or untrue, MetLife may have the right to deny benefits or rescind your coverage.

**Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.

**X** \_\_\_\_\_  
Signature of **APPLICANT A**

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of Licensed and Appointed Agent/Producer

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of **APPLICANT B**

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of Licensed and Appointed Agent/Producer

\_\_\_\_\_  
Date Signed at City, State

LSAAPP-IND-AR

Agent/Producer Distribution Channel:  MetLife  NEF  MLR  General Agent/Producer  Other \_\_\_\_\_ (Firm Name)

**PART A PERSON APPLYING FOR COVERAGE** (You must complete ALL information below.)

E New Business Policy # \_\_\_\_\_ [(ADG only)]

Multi-Life Group #: \_\_\_\_\_ Multi-Life Group Name \_\_\_\_\_

- 1. Relationship to Employee/Member:  
 Self  Retiree  
 Spouse or Domestic Partner\*  Parent (includes in-laws)  
 Adult Child  Grandparent (includes in-laws)]
- 2.  Mr.  Mrs.  Ms.  Dr. (check one)
- 3. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_
- 4. Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_
- 5. Preferred Contact Phone Number ( ) \_\_\_\_\_  
Additional Phone Number ( ) \_\_\_\_\_  
Best time to call  Morning  Afternoon  Evening
- 6. E-mail address \_\_\_\_\_
- 7. Gender  Male  Female
- 8. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)  
[Place of Birth \_\_\_\_\_ (State & Country)]
- 9. [Social Security Number] \_\_\_\_\_
- 10. Marital Status  
 Single/Widowed/Divorced  
 Married  
 Domestic Partner\*

- 11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO  
IF YES please identify and provide requested information.  
 Spouse or Domestic Partner\*  Household Member  
Name \_\_\_\_\_  
[Social Security Number] \_\_\_\_\_
- 12. Are you eligible for and applying for Simplified Underwriting?  
 YES  NO
- 13. Is the employer contributing to your premium?  YES  NO  
[IF YES is Employee or Spouse or Domestic Partner eligible for split billing?  YES  NO]
- If you are the Employee/Member:**
- 14. Name of your Employer: \_\_\_\_\_
- 15. Date of Hire: \_\_\_\_\_ (mm/dd/yyyy)  
Benefit Eligibility Date (if differs from hire date): \_\_\_\_\_  
Title/Position \_\_\_\_\_
- 16. Employee I.D. (if applicable) \_\_\_\_\_
- [17. Are you actively at work\*\* [30 hours] per week or more?  
 YES  NO]
- 18. If you are NOT the Employee/Member, please provide the Employee/Member's:  
Name \_\_\_\_\_  
[Social Security Number] \_\_\_\_\_
- 19. This is a request for  New Coverage  
 Increase in Existing Coverage

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

\*\*Actively at Work means that you are working at your usual place of employment, or other location to which your employer requires you to travel, and are performing all of the usual and customary duties of your occupation on a regular full-time basis, on the date this application is signed.]

Select either Simple Advantage **OR** Custom Advantage

**Simple Advantage** (Only available to applicants age 61 and under.)

**STEP 1 – Select the Maximum Amount of Initial Coverage you want:** (Select one box)

This plan includes Guaranteed Purchase Option Rider.  
 [(For Simplified Underwriting, selection can not exceed \$300K.)]

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT					
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K
\$3K	<input type="checkbox"/>	–				
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

- Shared Care Rider\*                     
  Nonforfeiture Coverage Rider                     
  Cash Benefit Rider]
- [\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

**OR**

**Custom Advantage**

**STEP 1 – Select the Maximum Amount of Coverage you want:** (Select one box)

(For Simplified Underwriting, selection can not exceed [\$9K Monthly Benefit Amount or \$500K Total Benefit Amount].)

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT						
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K	\$1MM
\$3K	<input type="checkbox"/>	–	–				
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	–
\$9K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$12K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15K	–	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

- Shared Care Rider\*                     
  Nonforfeiture Coverage Rider                     
  Cash Benefit Rider\*\*]
- [\* Available to Spouses or Domestic Partners who are applying for identical coverage.]  
 [\*\* Not available with \$1MM Total Benefit Amount.]

**STEP 3 – Select a Benefit Increase option:** (Select one box)

- Future Purchase Rider]                     
  5% Automatic Compound Inflation Protection Rider  
 3% Automatic Compound Inflation Protection Rider]                     
  I do not choose a Benefit Increase option.]

**PART C****INSURABILITY QUESTIONS**

If you have any doubt about your answers, ask your doctor.

**SIMPLIFIED UNDERWRITING** – Answer questions in Part C. If all answers are **NO**, skip Part D and continue to Part E. [If you answer **YES** to question 6, you must answer all of the questions in Part D and continue the application.]

**MODIFIED UNDERWRITING** – Answer questions in all sections.

1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Transient Ischemic Attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<b>TIA within the past [2 years]</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Organic brain syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication		
<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia		
<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>
			Muscular dystrophy	<input type="checkbox"/>
			Multiple sclerosis	<input type="checkbox"/>
			Parkinson's disease	<input type="checkbox"/>
			Huntington's chorea	<input type="checkbox"/>
			Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated <b>within the past [12 months]</b> (except basal or squamous cell of the skin)	<input type="checkbox"/>
			Diabetes with complications (e.g. amputation, kidney disease, eye disease, nerve disease); and/or diabetes combined with heart attack, bypass surgery, angina and/or TIA	<input type="checkbox"/>
			Organ transplant completed or medically advised	<input type="checkbox"/>
2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?			<input type="checkbox"/>	<input type="checkbox"/>
3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?			<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?			<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?			<input type="checkbox"/>	<input type="checkbox"/>
[6. <b>Within the past [2 years]</b> , have you had an application for MetLife Long-Term Care Insurance declined, postponed or rated less than standard? <b>IF YES</b> please answer all the questions in Part D. We will review your information and determine if you can be approved for coverage. We may need to contact you for additional information.]			<input type="checkbox"/>	<input type="checkbox"/>
<b>SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY</b>				
<b>Complete this section if:</b> You are part of a Simplified Underwriting group, you are under age 66, and your Spouse or Domestic Partner's employer is paying the premium.				
7. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication? <b>IF YES</b> please explain: _____			<input type="checkbox"/>	<input type="checkbox"/>
This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.				

**PART D****HEALTH QUESTIONS** (Provide additional information in the DETAILS section on [page 5], if needed.)**SKIP PART D IF SIMPLIFIED UNDERWRITING****Primary Care Physician (with most of your records)**

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART D HEALTH QUESTIONS – continued** (Provide additional information in the DETAILS section on [page 5], if needed.)

If you have any doubt about your answers, ask your doctor.

**Underwriting requirements:** Applicants ages [66-69], inclusive, will have a phone health interview. Applicants ages [70-84], inclusive, will require a face-to-face interview in their place of residence. Additionally, we may conduct a phone or face-to-face health interview regardless of age, to clarify health status.

1. Have you **ever** had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease/circulatory conditions / hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung disease / Chronic Obstructive Pulmonary disease (COPD)/emphysema	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver disease / hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
		Disorders of the brain / spinal cord	<input type="checkbox"/>	<input type="checkbox"/>
		Psychiatric condition(s) / mood disorders / depression / anxiety	<input type="checkbox"/>	<input type="checkbox"/>
		Arthritis / joint replacement / fractured hip	<input type="checkbox"/>	<input type="checkbox"/>
		Connective tissue condition(s) / lupus / scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
		Tremor / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
		Muscle / back disorders	<input type="checkbox"/>	<input type="checkbox"/>
		Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you have any other medical condition(s), planned surgery or medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?

YES  NO

3. Have you **ever** had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?

YES  NO

4. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?

YES  NO

5. Did you answer **YES** to any question 1-4? **IF YES** provide details below for **each YES** answer.

YES  NO

Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)

6. Have you taken any medications (excluding vitamins) or supplements **within the past 12 months?** **IF YES** provide details below for **each** medication.

YES  NO

Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional

7. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) **within the past 2 years?** **IF YES** indicate date of last use. \_\_\_\_\_mm/dd/yyyy

YES  NO

8. Do you consume alcoholic beverages?  
How often? \_\_\_\_\_ How much? \_\_\_\_\_

YES  NO

9. Have you **ever** been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? **IF YES** indicate date of last treatment. \_\_\_\_\_mm/dd/yyyy

YES  NO

10. What is your: height (in inches)? \_\_\_\_\_ weight (in pounds)? \_\_\_\_\_

YES  NO

11. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? **IF YES**, please describe.

YES  NO

I am employed: Job/Title \_\_\_\_\_ Hours/Week \_\_\_\_\_

I participate in other activities: \_\_\_\_\_ Hours/Week \_\_\_\_\_



**PART F**

**PAYMENT SELECTIONS**

**[1. Choose only ONE Premium Payment Option:**

- Standard
- Ten Year Premium Payment Rider\*

\*Not available with Simple Advantage or the Future Purchase Rider.

\*If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.

\*If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]

**2. Choose only ONE of the payment methods below.**

Please note there is an additional cost if you pay premiums more frequently than annually.

- a)  Employer List Bill/Payroll Deduction

This option may only be selected if available through your employer, and then is only open to employees [and their Spouses or Domestic Partners]. Deduction will be made from the payroll of the employee. [Employee must sign this authorization even if application is for Spouse or Domestic Partner.]

**Authorization:** I authorize the required premium for the coverage level selected to be deducted from my pay.

**X** \_\_\_\_\_ Date \_\_\_\_\_

Signature of Employee (if any portion of the premium is to be payroll deducted)

Date

Note: If premium is 100% employer funded, please write "100% Employer Paid" above.

- b)  Annual Direct Bill
- Semi-Annual Direct Bill
- Quarterly Direct Bill
- Monthly Direct Bill

**If you would like your bill sent to an address other than the address listed in Part A, please indicate below.**

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- [c]  Monthly Automatic Checking Account Deduction

**Electronic Payment Agreement Authorization**

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

**Enclose a voided blank check for the account you wish to use. DO NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number ( ) \_\_\_\_\_

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

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

**X** \_\_\_\_\_ ]

Signature of Account Holder

Date

**Required Information. Please check to indicate that you have received all of the following items:**

- Privacy Notice
- Potential Rate Increase Disclosure Form
- Outline of Coverage
- Shopper's Guide to Long-Term Care Insurance
- Replacement Notice (if this is a replacement policy)

#### Protection Against Unintended Lapse

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

- I elect NOT to designate a person to receive this notice.
- I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_

- Rejection of 5% Automatic Compound Inflation Protection Rider** (if applicable)

I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection Rider.

- Rejection of Nonforfeiture Coverage Rider** (if applicable)

I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider.

- I authorize any refund or overpayment** to be applied to my spouse or domestic partner's policy. I understand that any balance remaining will be refunded to me pursuant to the terms of my policy.

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

I understand that except as stated in the Conditional Premium Receipt, MetLife will have no liability until a policy is personally delivered to me and the full first modal premium amount is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change then the coverage change will take effect on the effective date of the change.

I understand all statements made on this application are representations and not warranties. I understand that: (1) the policy, if no Conditional Premium Receipt has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife, in writing, if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is delivered to me; or (2) the date on which any coverage change is scheduled to go into effect.

Wherever my initials appear in this application, it shall have the same force and effect as if I had signed my name in full on the date shown at the end of this section.



Agent/Producer Distribution Channel:  MetLife  NEF  MLR  General Agent/Producer  Other \_\_\_\_\_ (Firm Name)

**PART A PERSON(S) APPLYING FOR COVERAGE** (Each applicant must complete ALL information below.)

**APPLICANT A**

E New Business Policy # \_\_\_\_\_ [(ADG only)]

1.  Mr.  Mrs.  Ms.  Dr. (check one)

2. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

3. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Preferred Contact Phone Number ( ) \_\_\_\_\_

Additional Phone Number ( ) \_\_\_\_\_

Best time to call  Morning  Afternoon  Evening

5. E-mail address \_\_\_\_\_

6. Gender  Male  Female

7. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

[Place of Birth \_\_\_\_\_ (State & Country)]

8. Height \_\_\_\_\_ Weight \_\_\_\_\_

9. [Social Security Number] \_\_\_\_\_

10. Marital Status  Single/Widowed/Divorced

Married

Domestic Partner\*

11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO

IF YES please identify and provide requested information.

Spouse or Domestic Partner\*  Household Member

Name \_\_\_\_\_

[Social Security Number] \_\_\_\_\_

12. This is a request for  New Coverage

Increase of Existing Coverage

Exercise Life or DI GPO Rider

**APPLICANT B**

Is APPLICANT A your

Spouse or Domestic Partner\*  Household Member

1.  Mr.  Mrs.  Ms.  Dr. (check one)

2. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Last Name \_\_\_\_\_

3. Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Preferred Contact Phone Number ( ) \_\_\_\_\_

Additional Phone Number ( ) \_\_\_\_\_

Best time to call  Morning  Afternoon  Evening

5. E-mail address \_\_\_\_\_

6. Gender  Male  Female

7. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)

[Place of Birth \_\_\_\_\_ (State & Country)]

8. Height \_\_\_\_\_ Weight \_\_\_\_\_

9. [Social Security Number] \_\_\_\_\_

10. Marital Status  Single/Widowed/Divorced

Married

Domestic Partner\*

11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO

IF YES please identify and provide requested information.

Spouse or Domestic Partner\*  Household Member

Name \_\_\_\_\_

[Social Security Number] \_\_\_\_\_

12. This is a request for  New Coverage

Increase of Existing Coverage

Exercise Life or DI GPO Rider

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

<b>PART B</b>	<b>COVERAGE SELECTIONS</b>
<b>1 – Select Your Plan of Coverage:</b> <b>APPLICANT A</b> <input type="checkbox"/> Value <input type="checkbox"/> Ideal <input type="checkbox"/> Premier <input type="checkbox"/> Facilities-Only]	<b>APPLICANT B</b> <input type="checkbox"/> Value <input type="checkbox"/> Ideal <input type="checkbox"/> Premier <input type="checkbox"/> Facilities-Only]
<b>2 – Select Your Maximum Nursing Home Daily Benefit Amount (“DBA”):</b> <b>APPLICANT A</b> DBA: \$ _____ (\$50 to \$400 per day in \$10 increments)	<b>APPLICANT B</b> DBA: \$ _____ (\$50 to \$400 per day in \$10 increments)
<b>3 – Select Your Benefit Period Multiplier: (Your Total Lifetime Benefit = Benefit Period x DBA)</b> <b>APPLICANT A</b> <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"/> 2,190 (6-year) <input type="checkbox"/> 2,555 (7-year)]	<b>APPLICANT B</b> <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"/> 2,190 (6-year) <input type="checkbox"/> 2,555 (7-year)]
<b>4 – Select Your Home/Community-Based Care Benefit %*:</b> (Do not select any if you chose Facilities Only.)	
<b>APPLICANT A</b> <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50%	<b>APPLICANT B</b> <input type="checkbox"/> 100% <input type="checkbox"/> 75% <input type="checkbox"/> 50%
* For Value: Home Care and Assisted Living Facility Care paid at this percentage of the DBA. * For Ideal: Home Care paid at this percentage of the DBA. [*For Premier: Basic Daily Benefit paid at this percentage of the DBA.]	
<b>5 – Select an Elimination Period:</b> <b>APPLICANT A</b> <input type="checkbox"/> 20 Days <input type="checkbox"/> 45 Days <input type="checkbox"/> 100 Days]	<b>APPLICANT B</b> <input type="checkbox"/> 20 Days <input type="checkbox"/> 45 Days <input type="checkbox"/> 100 Days]
<b>6 – Select Optional Riders:</b> <b>APPLICANT A</b> [Choose ONE Enhanced Elimination Period Option if desired. <input type="checkbox"/> Calendar Day Rider (Not available with Premier or Facilities Only) <input type="checkbox"/> Home Care EP Waiver (Not available with Premier or Facilities Only)  Choose Benefit Riders as desired. <input type="checkbox"/> Return of Premium – To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife. <input type="checkbox"/> Indemnity (Only available with Value Policy) <input type="checkbox"/> Restoration of Benefits (Not available with Premier or Shared Care Rider) <input type="checkbox"/> Shared Care (Not available with Restoration of Benefits Rider. Spouse or Domestic Partner must have identical coverage.) <input type="checkbox"/> Paid-Up Survivorship]	<b>APPLICANT B</b> [Choose ONE Enhanced Elimination Period Option if desired. <input type="checkbox"/> Calendar Day Rider (Not available with Premier or Facilities Only) <input type="checkbox"/> Home Care EP Waiver (Not available with Premier or Facilities Only)  Choose Benefit Riders as desired. <input type="checkbox"/> Return of Premium – To designate a beneficiary under this rider, you must complete the Beneficiary Designation Form required by MetLife. <input type="checkbox"/> Indemnity (Only available with Value Policy) <input type="checkbox"/> Restoration of Benefits (Not available with Premier or Shared Care Rider) <input type="checkbox"/> Shared Care (Not available with Restoration of Benefits Rider. Spouse or Domestic Partner must have identical coverage.) <input type="checkbox"/> Paid-Up Survivorship]
<b>7 – Benefit Increase Options (Choose one)</b>	
<b>APPLICANT A</b> <input type="checkbox"/> 5% Automatic Compound Inflation Protection Rider <input type="checkbox"/> 5% Automatic Simple Inflation Protection Rider <input type="checkbox"/> Future Purchase Rider* <input type="checkbox"/> I DO NOT choose Inflation Protection]	<b>APPLICANT B</b> <input type="checkbox"/> 5% Automatic Compound Inflation Protection Rider <input type="checkbox"/> 5% Automatic Simple Inflation Protection Rider <input type="checkbox"/> Future Purchase Rider* <input type="checkbox"/> I DO NOT choose Inflation Protection]
[* Not available if an Accelerated Premium Payment Rider is selected.]	
<b>8 – Nonforfeiture Coverage Rider:</b> <b>APPLICANT A</b> <input type="checkbox"/> YES <input type="checkbox"/> NO I select Nonforfeiture Coverage Rider	<b>APPLICANT B</b> <input type="checkbox"/> YES <input type="checkbox"/> NO I select Nonforfeiture Coverage Rider

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

APPLICANT A		If you have any doubt about your answers, ask your doctor.	APPLICANT B	
YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke <b>within the past [5 years]</b> , multiple strokes, stroke with residual impairment, Transient Ischemic Attack (TIA) <b>within the past [2 years]</b> , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

**Primary Care Physician (with most of your records)**

**APPLICANT A**

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

**APPLICANT B**

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

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

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Physician \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

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

You are required to answer all the questions in this section. Missing information will result in underwriting delays.

**If you have any doubt about your answers, ask your doctor.**

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

APPLICANT A		1. Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for:	APPLICANT B		APPLICANT A			APPLICANT B	
YES	NO		YES	NO	YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack / angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus / Scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery / angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement / fractures / falls	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis / amputation / weakness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory / lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney / bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / brain condition(s) / head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremor / imbalance / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Spine / back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Depression / anxiety / bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	3. <b>Within the past 12 months</b> , have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	5. Have you <b>ever</b> resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	6. Have you <b>ever</b> had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	7. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>	

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

APPLICANT A							APPLICANT B		
YES	NO						YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	8. Did you answer <b>YES</b> to any question 1-7? <b>IF YES</b> provide details below for <b>each</b> question for <b>each</b> applicant (separately).					<input type="checkbox"/>	<input type="checkbox"/>	
		Select Applicant	Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)			Name of Treating Health Professional(s)
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
<input type="checkbox"/>	<input type="checkbox"/>	9. Have you taken any medications (excluding vitamins) or supplements <b>within the past 12 months</b> ? <b>IF YES</b> provide details below for <b>each</b> medication taken for <b>each</b> applicant (separately).					<input type="checkbox"/>	<input type="checkbox"/>	
		Select Applicant	Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
		<input type="checkbox"/> A <input type="checkbox"/> B							
<input type="checkbox"/>	<input type="checkbox"/>	10. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) <b>within the past 2 years</b> ? <b>IF YES</b> indicate date of last use. <b>APPLICANT A</b> _____ mm/dd/yyyy   <b>APPLICANT B</b> _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	11. Do you consume alcoholic beverages? <b>APPLICANT A</b> How often? _____ How much? _____   <b>APPLICANT B</b> How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	12. Have you <b>ever</b> been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? <b>IF YES</b> indicate date of last treatment. <b>APPLICANT A</b> _____ mm/dd/yyyy   <b>APPLICANT B</b> _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had a weight gain or loss of 10 pounds or more <b>within the past 12 months</b> ? <b>IF YES</b> please specify: <b>APPLICANT A</b> Pounds lost _____ Pounds gained _____   <b>APPLICANT B</b> Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	14. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? <b>IF YES</b> , please describe. <b>APPLICANT A</b> <input type="checkbox"/> I am employed: Job/Title _____ Hours/ Week _____ <input type="checkbox"/> I participate in other activities: _____ Hours/ Week _____   <b>APPLICANT B</b> <input type="checkbox"/> I am employed: Job/Title _____ Hours/ Week _____ <input type="checkbox"/> I participate in other activities: _____ Hours/ Week _____					<input type="checkbox"/>	<input type="checkbox"/>	



<b>PART F</b>		<b>PAYMENT SELECTIONS</b>													
APPLICANT A			APPLICANT B												
<input type="checkbox"/> Standard Mode <input type="checkbox"/> Accelerated Payment Riders*: <input type="checkbox"/> Double Pay First Year Rider <input type="checkbox"/> Reduced Pay at Age 65 Rider <input type="checkbox"/> Paid-Up Premiums Rider <input type="checkbox"/> Ten Year Premium Payment Rider**	<p><b>[1. Choose Standard Mode OR one of the Accelerated Payment Riders:</b></p> <p style="text-align: right;">Standard Mode</p> <p style="text-align: right;"><b>Accelerated Payment Riders*:</b></p> <p style="text-align: right;">Double Pay First Year Rider</p> <p style="text-align: right;">Reduced Pay at Age 65 Rider</p> <p style="text-align: right;">Paid-Up Premiums Rider</p> <p style="text-align: right;">Ten Year Premium Payment Rider**</p> <p style="text-align: center; font-size: small;">*Not available with Future Purchase Rider.                      **If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.                      **If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]</p>	<input type="checkbox"/> Standard Mode <input type="checkbox"/> Accelerated Payment Riders*: <input type="checkbox"/> Double Pay First Year Rider <input type="checkbox"/> Reduced Pay at Age 65 Rider <input type="checkbox"/> Paid-Up Premiums Rider <input type="checkbox"/> Ten Year Premium Payment Rider**													
<input type="checkbox"/> Annual Direct Bill <input type="checkbox"/> Semi-Annual Direct Bill <input type="checkbox"/> Quarterly Direct Bill <input type="checkbox"/> Monthly Direct Bill]	<p><b>2. Choose only ONE of the payment methods below.</b>                      Please note there is an additional cost if you pay premiums more frequently than annually.</p> <p style="text-align: right;">Annual Direct Bill</p> <p style="text-align: right;">Semi-Annual Direct Bill</p> <p style="text-align: right;">Quarterly Direct Bill</p> <p style="text-align: right;">[Monthly Direct Bill</p> <p><b>If you would like your bill sent to an address other than the address listed in Part A, please indicate below.</b></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid black; padding: 5px;"><b>APPLICANT A</b></td> <td style="width: 50%; padding: 5px;"><b>APPLICANT B</b></td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">Name _____</td> <td style="padding: 5px;">Name _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">Address _____</td> <td style="padding: 5px;">Address _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">City _____</td> <td style="padding: 5px;">City _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">State _____ Zip _____</td> <td style="padding: 5px;">State _____ Zip _____</td> </tr> <tr> <td style="border-right: 1px solid black; padding: 5px;">Phone Number ( ) _____</td> <td style="padding: 5px;">Phone Number ( ) _____</td> </tr> </table>	<b>APPLICANT A</b>	<b>APPLICANT B</b>	Name _____	Name _____	Address _____	Address _____	City _____	City _____	State _____ Zip _____	State _____ Zip _____	Phone Number ( ) _____	Phone Number ( ) _____	<input type="checkbox"/> Annual Direct Bill <input type="checkbox"/> Semi-Annual Direct Bill <input type="checkbox"/> Quarterly Direct Bill <input type="checkbox"/> [Monthly Direct Bill]	
<b>APPLICANT A</b>	<b>APPLICANT B</b>														
Name _____	Name _____														
Address _____	Address _____														
City _____	City _____														
State _____ Zip _____	State _____ Zip _____														
Phone Number ( ) _____	Phone Number ( ) _____														
<input type="checkbox"/> Monthly Automatic Checking Account Deduction	<p><b>Monthly Automatic Checking Account Deduction</b></p> <p><b>Electronic Payment Agreement Authorization</b></p> <p>Your monthly premium will be deducted automatically from the bank or credit union checking account you request. <b>Enclose a voided blank check for the account you wish to use. DO NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.</b> If using a credit union account, please provide credit union phone number.</p> <p><b>APPLICANT A:</b> Credit Union Phone Number ( ) _____</p> <p><b>APPLICANT B:</b> Credit Union Phone Number ( ) _____</p> <p><b>I authorize:</b> (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.</p> <p><b>APPLICANT A:</b> By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <p><b>APPLICANT B:</b> By signing below, I represent that I am an authorized account holder of this checking account and I authorize deductions to be taken on the _____ day of the month, or the next business day. If no day is selected, deductions will be taken on the first business day of the month.</p> <p><b>X</b> _____ Date _____</p> <p style="text-align: center; font-size: small;">Signature of Account Holder for <b>APPLICANT A</b></p> <p><b>X</b> _____ Date _____</p> <p style="text-align: center; font-size: small;">Signature of Account Holder for <b>APPLICANT B</b></p>	<input type="checkbox"/> Monthly Automatic Checking Account Deduction													



**PART G**

**AGREEMENT AND ACKNOWLEDGEMENT – *continued***

**Your signature below:** Confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected 5% Automatic Compound Inflation Protection Rider, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection Rider and your rejection of 5% Automatic Compound Inflation Protection Rider.

**Caution:** If your answers or statements on this application are misstated or untrue, MetLife may have the right to deny benefits or rescind your coverage.

**Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.

**X** \_\_\_\_\_  
Signature of **APPLICANT A**

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of Licensed and Appointed Agent/Producer

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of **APPLICANT B**

\_\_\_\_\_  
Date Signed at City, State

**X** \_\_\_\_\_  
Signature of Licensed and Appointed Agent/Producer

\_\_\_\_\_  
Date Signed at City, State

VIP2APP-IND-AR

Agent/Producer Distribution Channel:  MetLife  NEF  MLR  General Agent/Producer  Other \_\_\_\_\_ (Firm Name)

**PART A PERSON APPLYING FOR COVERAGE** (You must complete ALL information below.)

E New Business Policy # \_\_\_\_\_ [(ADG only)]

Multi-Life Group #: \_\_\_\_\_ Multi-Life Group Name \_\_\_\_\_

- 1. Relationship to Employee/Member:  
 Self  Retiree  
 Spouse or Domestic Partner\*  Parent (includes in-laws)  
 Adult Child  Grandparent (includes in-laws)]
- 2.  Mr.  Mrs.  Ms.  Dr. (check one)
- 3. First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Last Name \_\_\_\_\_
- 4. Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_
- 5. Preferred Contact Phone Number ( ) \_\_\_\_\_  
Additional Phone Number ( ) \_\_\_\_\_  
Best time to call  Morning  Afternoon  Evening
- 6. E-mail address \_\_\_\_\_
- 7. Gender  Male  Female
- 8. Date of Birth \_\_\_\_\_ (mm/dd/yyyy)  
[Place of Birth \_\_\_\_\_ (State & Country)]
- 9. [Social Security Number] \_\_\_\_\_
- 10. Marital Status  
 Single/Widowed/Divorced  
 Married  
 Domestic Partner\*

- 11. Is your Spouse or Domestic Partner\* or your household member applying for or do they already have an Individual LTC Insurance policy issued by MetLife?  YES  NO  
IF YES please identify and provide requested information.  
 Spouse or Domestic Partner\*  Household Member  
Name \_\_\_\_\_  
[Social Security Number] \_\_\_\_\_
- 12. Are you eligible for and applying for Simplified Underwriting?  
 YES  NO
- 13. Is the employer contributing to your premium?  YES  NO  
[IF YES is Employee or Spouse or Domestic Partner eligible for split billing?  YES  NO]
- If you are the Employee/Member:**
- 14. Name of your Employer: \_\_\_\_\_
- 15. Date of Hire: \_\_\_\_\_ (mm/dd/yyyy)  
Benefit Eligibility Date (if differs from hire date): \_\_\_\_\_  
Title/Position \_\_\_\_\_
- 16. Employee I.D. (if applicable) \_\_\_\_\_
- [17. Are you actively at work\*\* [30 hours] per week or more?  
 YES  NO]
- 18. If you are NOT the Employee/Member, please provide the Employee/Member's:  
Name \_\_\_\_\_  
[Social Security Number] \_\_\_\_\_
- 19. This is a request for  New Coverage  
 Increase in Existing Coverage

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

\*\*Actively at Work means that you are working at your usual place of employment, or other location to which your employer requires you to travel, and are performing all of the usual and customary duties of your occupation on a regular full-time basis, on the date this application is signed.]

**PART B****COVERAGE SELECTIONS****1 – Select Your Plan of Coverage:**

Value       Ideal       Premier       Facilities-Only]

**2 – Select Your Maximum Nursing Home Daily Benefit Amount (“DBA”):**

DBA: \$ \_\_\_\_\_ (\$50 to \$400\* per day in \$10 increments)

\* For Simplified Underwriting, DBA cannot exceed [\$300] per day.

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

730 (2-year)       1,095 (3-year)       1,460 (4-year)  
 1,825 (5-year)       2,190 (6-year)\*       2,555 (7-year)\*

\* For Simplified Underwriting Benefit Period cannot exceed 5 years.]

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

100%       75%       50%]

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

\* **For Ideal:** Home Care paid at this percentage of the DBA.

**[\*For Premier:** Basic Daily Benefit paid at this percentage of the DBA.]

**5 – Select an Elimination Period:**

20 Days       45 Days       100 Days]

**6 – Select Optional Riders:**

**[Choose ONE Enhanced Elimination Period Option if desired.**

- Calendar Day Rider (Not available with Premier or Facilities Only)  
 Home Care EP Waiver (Not available with Premier or Facilities Only)

**Choose Benefit Riders as desired.**

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

**7 – Benefit Increase Options** (Choose one)

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

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

**8 – Nonforfeiture Coverage Rider:**

I select Nonforfeiture Coverage Rider     YES     NO

**PART C**

**INSURABILITY QUESTIONS**

If you have any doubt about your answers, ask your doctor.

**SIMPLIFIED UNDERWRITING** – Answer questions in Part C. If all answers are **NO**, skip Part D and continue to Part E. [If you answer **YES** to question 6, you must answer all of the questions in Part D and continue the application.]

**MODIFIED UNDERWRITING** – Answer questions in all sections.

1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Transient Ischemic Attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<b>TIA within the past [2 years]</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Organic brain syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication		
<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia		
<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>
		Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
		Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
		Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
		Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>
		Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated <b>within the past [12 months]</b> (except basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
		Diabetes with complications (e.g. amputation, kidney disease, eye disease, nerve disease); and/or diabetes combined with heart attack, bypass surgery, angina and/or TIA	<input type="checkbox"/>	<input type="checkbox"/>
		Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
		2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
		3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
		4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
		5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>
		[6. <b>Within the past [2 years]</b> , have you had an application for MetLife Long-Term Care Insurance declined, postponed or rated less than standard? <b>IF YES</b> please answer all the questions in Part D. We will review your information and determine if you can be approved for coverage. We may need to contact you for additional information.]	<input type="checkbox"/>	<input type="checkbox"/>

**SPOUSE OR DOMESTIC PARTNER OF EMPLOYEES ONLY**

**Complete this section if:** You are part of a Simplified Underwriting group, you are under age 66, and your Spouse or Domestic Partner's employer is paying the premium.

7. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?

**IF YES** please explain: \_\_\_\_\_

This information will be reviewed to determine if the coverage you selected can be approved. We may need to contact you for additional information.

**PART D HEALTH QUESTIONS** (Provide additional information in the DETAILS section on [page 5], if needed.)

**SKIP PART D IF SIMPLIFIED UNDERWRITING**

**Primary Care Physician (with most of your records)**

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PART D HEALTH QUESTIONS – continued** (Provide additional information in the DETAILS section on [page 5], if needed.)

If you have any doubt about your answers, ask your doctor.

**Underwriting requirements:** Applicants ages [66-69], inclusive, will have a phone health interview. Applicants ages [70-84], inclusive, will require a face-to-face interview in their place of residence. Additionally, we may conduct a phone or face-to-face health interview regardless of age, to clarify health status.

1. Have you **ever** had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / circulatory conditions / hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung disease / Chronic Obstructive Pulmonary disease (COPD)/emphysema	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic liver disease / hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
		Disorders of the brain / spinal cord	<input type="checkbox"/>	<input type="checkbox"/>
		Psychiatric condition(s) / mood disorders / depression / anxiety	<input type="checkbox"/>	<input type="checkbox"/>
		Arthritis / joint replacement / fractured hip	<input type="checkbox"/>	<input type="checkbox"/>
		Connective tissue condition(s) / lupus / scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
		Tremor / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
		Muscle / back disorders	<input type="checkbox"/>	<input type="checkbox"/>
		Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you have any other medical condition(s), planned surgery or medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?

YES  NO

3. Have you **ever** had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?

YES  NO

4. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?

YES  NO

5. Did you answer **YES** to any question 1-4? **IF YES** provide details below for **each YES** answer.

YES  NO

Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)

6. Have you taken any medications (excluding vitamins) or supplements **within the past 12 months?** **IF YES** provide details below for **each** medication.

YES  NO

Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional

7. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) **within the past 2 years?** **IF YES** indicate date of last use. \_\_\_\_\_mm/dd/yyyy

YES  NO

8. Do you consume alcoholic beverages?  
How often? \_\_\_\_\_ How much? \_\_\_\_\_

YES  NO

9. Have you **ever** been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? **IF YES** indicate date of last treatment. \_\_\_\_\_mm/dd/yyyy

YES  NO

10. What is your: height (in inches)? \_\_\_\_\_ weight (in pounds)? \_\_\_\_\_

YES  NO

11. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? **IF YES**, please describe.

YES  NO

I am employed: Job/Title \_\_\_\_\_ Hours/Week \_\_\_\_\_

I participate in other activities: \_\_\_\_\_ Hours/Week \_\_\_\_\_



**PART F**

**PAYMENT SELECTIONS**

**[1. Choose Standard Mode OR one of the Accelerated Payment Riders:**

Standard Mode

**Accelerated Payment Riders\*:**

Double Pay First Year Rider

Reduced Pay at Age 65 Rider

Paid-Up Premiums Rider

Ten Year Premium Payment Rider\*\*

\*Not available with Future Purchase Rider.

\*\*If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.

\*\*If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]

**2. Choose only ONE of the payment methods below.**

Please note there is an additional cost if you pay premiums more frequently than annually.

a)  Employer List Bill/Payroll Deduction

This option may only be selected if available through your employer, and then is only open to employees [and their Spouses or Domestic Partners]. Deduction will be made from the payroll of the employee. [Employee must sign this authorization even if application is for Spouse or Domestic Partner.]

**Authorization:** I authorize the required premium for the coverage level selected to be deducted from my pay.

**X** \_\_\_\_\_

Signature of Employee (if any portion of the premium is to be payroll deducted)

\_\_\_\_\_ Date

Note: If premium is 100% employer funded, please write "100% Employer Paid" above.

b)  Annual Direct Bill

Semi-Annual Direct Bill

Quarterly Direct Bill

Monthly Direct Bill

**If you would like your bill sent to an address other than the address listed in Part A, please indicate below.**

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

[c)  Monthly Automatic Checking Account Deduction

**Electronic Payment Agreement Authorization**

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

**Enclose a voided blank check for the account you wish to use. DO NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number ( ) \_\_\_\_\_

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

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

**X** \_\_\_\_\_ ]

Signature of Account Holder

\_\_\_\_\_ Date

**Required Information. Please check to indicate that you have received all of the following items:**

- Privacy Notice
- Potential Rate Increase Disclosure Form
- Outline of Coverage
- Shopper's Guide to Long-Term Care Insurance
- Replacement Notice (if this is a replacement policy)

**Protection Against Unintended Lapse**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

- I elect NOT to designate a person to receive this notice.
- I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship \_\_\_\_\_

- Rejection of 5% Automatic Compound Inflation Protection Rider** (if applicable)

I have reviewed the Outline of Coverage for the policy applied for, and the graphs that compare a policy with and without the 5% Automatic Compound Inflation Protection Rider. Specifically, I have reviewed the options offered, and I reject the 5% Automatic Compound Inflation Protection Rider.

- Rejection of Nonforfeiture Coverage Rider** (if applicable)

I have reviewed the Outline of Coverage and the Nonforfeiture Coverage Rider as described therein. Specifically, I have reviewed the plan with the Nonforfeiture Coverage and I reject the Nonforfeiture Coverage Rider.

- I authorize any refund or overpayment to be applied to my spouse or domestic partner's policy. I understand that any balance remaining will be refunded to me pursuant to the terms of my policy.

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

I understand that except as stated in the Conditional Premium Receipt, MetLife will have no liability until a policy is personally delivered to me and the full first modal premium amount is paid. The policy will then be in effect, subject to the terms set forth in the next paragraph. If this is an application for a coverage change then the coverage change will take effect on the effective date of the change.

I understand all statements made on this application are representations and not warranties. I understand that: (1) the policy, if no Conditional Premium Receipt has been issued; or (2) any coverage change that I am applying for, will not take effect unless on the date the policy is delivered to me or on the date such coverage change would otherwise be effective: (a) the condition of my health is the same as given in this application; and (b) I have not received any medical advice or treatment from a physician or other health care provider since the date of this application. I agree that I will inform MetLife, in writing, if there is a change in my health or if I have received any medical advice or treatment, as described above, between the date of this application and: (1) the date the policy is delivered to me; or (2) the date on which any coverage change is scheduled to go into effect.

Wherever my initials appear in this application, it shall have the same force and effect as if I had signed my name in full on the date shown at the end of this section.

**PART G**

**AGREEMENT AND ACKNOWLEDGEMENT – *continued***

**Your signature below:** Confirms your request for coverage; confirms your election concerning a Lapse Designee; and if you rejected 5% Automatic Compound Inflation Protection Rider, confirms your review of the information above concerning 5% Automatic Compound Inflation Protection Rider and your rejection of 5% Automatic Compound Inflation Protection Rider.

**Caution:** If your answers or statements on this application are misstated or untrue, MetLife may have the right to deny benefits or rescind your coverage.

**Fraud Warning:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have read the above answers and statements on this application. By signing below, I declare, to the best of my knowledge and belief, that all information supplied in this application is true and complete.

**X** \_\_\_\_\_ Date \_\_\_\_\_ Signed at City, State  
Signature of Applicant

**X** \_\_\_\_\_ Date \_\_\_\_\_ Signed at City, State  
Signature of Licensed and Appointed Agent/Producer

VIP2APP-ML-AR

Agent/Producer Distribution Channel:  MetLife  NEF  MLR  General Agent/Producer  Other \_\_\_\_\_ (Firm Name)

**Do not submit any payment with this application for reinstatement—MetLife does not accept any payments with applications for reinstatement. Reinstatement applications submitted with money will not be processed.**

**Submit the entire completed application to: [MetLife Long-Term Care, P.O. Box 64911, St. Paul, MN 55164-0911]**

**PART A PERSON APPLYING FOR REINSTATEMENT (You must complete ALL information below.)**

- |   |  |
|---|--|
| <p>1. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr. (check one)</p> <p>2. First Name _____ Middle Initial _____<br/>Last Name _____</p> <p>3. Address _____<br/>City _____ State _____ Zip _____</p> <p>4. Preferred Contact Phone Number ( ) _____<br/>Additional Phone Number ( ) _____<br/>Best time to call <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening</p> | <p>5. E-mail address _____</p> <p>6. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>7. Date of Birth _____ (mm/dd/yyyy)<br/>Place of Birth _____ (State &amp; Country)</p> <p>8. [Social Security Number] _____</p> <p>9. Height _____ Weight _____</p> <p>10. Policy form number you wish to reinstate _____</p> |
|---|--|

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

If you have any doubt about your answers, ask your doctor.	YES	NO
1. Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke <b>within the past [5 years]</b> , multiple strokes, stroke with residual impairment, Transient Ischemic Attack (TIA) <b>within the past [2 years]</b> , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/ AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>

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

**PART C HEALTH QUESTIONS** (Provide additional information in the DETAILS section on [page 4], if needed.)

**Primary Care Physician (with most of your records)**

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_ Date Last Seen \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

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

1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (excluding basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart disease / condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Atrial fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack / angina	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Heart surgery / angioplasty	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory / lung condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney / bladder condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Liver condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Endocrine condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Neurological condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures / brain condition(s) / head injury	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Spine / back condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Depression / anxiety / bipolar	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
		Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>
		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
		Connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
		Lupus / Scleroderma / CREST	<input type="checkbox"/>	<input type="checkbox"/>
		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
		Joint replacement / fractures / falls	<input type="checkbox"/>	<input type="checkbox"/>
		Paralysis / amputation / weakness	<input type="checkbox"/>	<input type="checkbox"/>
		Bladder / bowel incontinence	<input type="checkbox"/>	<input type="checkbox"/>
		Numbness of extremities	<input type="checkbox"/>	<input type="checkbox"/>
		Dizziness / fainting	<input type="checkbox"/>	<input type="checkbox"/>
		Muscle disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
		Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
		Chronic fatigue syndrome	<input type="checkbox"/>	<input type="checkbox"/>
		Polymyalgia rheumatica	<input type="checkbox"/>	<input type="checkbox"/>
		Tremor / imbalance / gait disturbance	<input type="checkbox"/>	<input type="checkbox"/>
		Memory loss / forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
		Ulcerative colitis / Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
		Blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>
		Hepatitis/cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
		2. Do you have any other medical condition(s), past or planned major surgery, planned medical testing, or any condition(s) for which you are seeking or plan to seek or have been advised to seek medical advice?	<input type="checkbox"/>	<input type="checkbox"/>
		3. <b>Within the past 12 months</b> , have you used any medical equipment (e.g. cane, brace, crutches, nebulizer, Continuous Positive Airway Pressure (CPAP))?	<input type="checkbox"/>	<input type="checkbox"/>

**PART C HEALTH QUESTIONS – continued** (Provide additional information in the DETAILS section on [page 4], if needed.)

					YES	NO
4. Do you need or receive help with any of the following activities because you are unable to perform them yourself: shopping, paying bills, meal preparation, transportation, laundry, or taking your medication?					<input type="checkbox"/>	<input type="checkbox"/>
5. Have you <b>ever</b> resided in, or used: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?					<input type="checkbox"/>	<input type="checkbox"/>
6. Have you <b>ever</b> had an application for Life, Health, Disability, or Long-Term Care Insurance declined, postponed, modified or rated less than standard?					<input type="checkbox"/>	<input type="checkbox"/>
7. Are you receiving or have you applied for or are you planning to apply for any disability payments or workers' compensation?					<input type="checkbox"/>	<input type="checkbox"/>
8. Did you answer <b>YES</b> to any question 1-7? <b>IF YES</b> provide details below for <b>each YES</b> answer.					<input type="checkbox"/>	<input type="checkbox"/>
Question Number	Diagnosis/Condition/Detail	Onset Date	Treatment Date(s)	Name of Treating Health Professional(s)		
9. Have you taken any medications (excluding vitamins) or supplements <b>within the past 12 months</b> ? <b>IF YES</b> provide details below for <b>each</b> medication.					<input type="checkbox"/>	<input type="checkbox"/>
Medication	Dosage/Frequency	Reason For Taking	Name of Prescribing Health Professional			
10. Have you used tobacco products (cigarettes, cigars, pipe, chewing tobacco) <b>within the past 2 years</b> ? <b>IF YES</b> indicate date of last use. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
11. Do you consume alcoholic beverages? How often? _____ How much? _____					<input type="checkbox"/>	<input type="checkbox"/>
12. Have you <b>ever</b> been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? <b>IF YES</b> indicate date of last treatment. _____ mm/dd/yyyy					<input type="checkbox"/>	<input type="checkbox"/>
13. Have you had a weight gain or loss of 10 pounds or more <b>within the past 12 months</b> ? <b>IF YES</b> please specify: Pounds lost _____ Pounds gained _____					<input type="checkbox"/>	<input type="checkbox"/>
14. Are you employed or do you participate in other activities (social or physical) outside your home on a regular basis? <b>IF YES</b> , please describe.					<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am employed: Job/Title _____ Hours/Week _____						
<input type="checkbox"/> I participate in other activities: _____ Hours/Week _____						





Today's Date \_\_\_\_\_  
mm/dd/yyyy

# MetLife LTC LifeStage Advantage<sup>SM</sup>

## LTC Insurance Preliminary Request Form

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

### PART A INSURABILITY QUESTIONS (Please ask your prospect these questions BEFORE submitting this form.)

If you have any doubt about your answers, ask your doctor.	YES	NO
1. Have you <b>ever</b> had, do you currently have, have you been medically diagnosed as having, or have you been treated for: Stroke <b>within the past [5 years]</b> , multiple strokes, stroke with residual impairment, Transient Ischemic Attack (TIA) <b>within the past [2 years]</b> , multiple TIA's; Alzheimer's disease; dementia/organic brain syndrome, memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication; mental retardation; schizophrenia; Parkinson's disease/syndrome; multiple sclerosis; muscular dystrophy; Amyotrophic Lateral Sclerosis (ALS); or Huntington's chorea?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; dialysis; or oxygen (except for sleep apnea)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?	<input type="checkbox"/>	<input type="checkbox"/>

**IF YES** was answered to any of Part A, questions 1–5, **PLEASE DO NOT CONTINUE.**  
We regret that we can not offer Long-Term Care Insurance coverage in this situation.

### PART B PROSPECT INFORMATION

Married or Domestic Partner\*    Single/Divorced/Widowed      [QuikMet Order Ticket No. \_\_\_\_\_]

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Client Account No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male    Female  
mm/dd/yyyy

Preferred Contact Phone No. \_\_\_\_\_ Additional Phone No. \_\_\_\_\_

Best time to call    Morning    Afternoon    Evening

Primary Care Physician Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is a Spouse or any other member of the prospect's household applying for or do they already have a MetLife Long-Term Care Insurance policy?    YES    NO   **IF YES** complete below.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

\*"Domestic Partner" means each of two people: (1) 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 (2) who meet the following requirements: (a) each person is 18 years of age or older; (b) neither person is married; (c) they share the same residence; (d) they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and (e) they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations and such commitment is expected to last indefinitely.

**Please attach any additional comments on a separate sheet.**

Select either Simple Advantage **OR** Custom Advantage

**Simple Advantage** (Only available to applicants age 61 and under.)

**STEP 1 – Select the Maximum Amount of Initial Coverage you want:** (Select one box)

This plan includes Guaranteed Purchase Option Rider.

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT					
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K
\$3K	<input type="checkbox"/>	–				
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

Shared Care Rider\*

Nonforfeiture Coverage Rider

Cash Benefit Rider]

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

**OR**

**Custom Advantage**

**STEP 1 – Select the Maximum Amount of Coverage you want:** (Select one box)

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT						
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K	\$1MM
\$3K	<input type="checkbox"/>	–	–				
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	–
\$9K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$12K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$15K	–	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

Shared Care Rider\*

Nonforfeiture Coverage Rider

Cash Benefit Rider\*\*]

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

[\*\* Not available with \$1MM Total Benefit Amount.]

**STEP 3 – Select a Benefit Increase option:** (Select one box)

Future Purchase Rider]

5% Automatic Compound Inflation Protection Rider

3% Automatic Compound Inflation Protection Rider]

I do not choose a Benefit Increase option.]





# MetLife LTC LifeStage Advantage<sup>SM</sup> LTC Insurance Preliminary Request Form

Today's Date \_\_\_\_\_  
mm/dd/yyyy

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

Multi-Life Group # \_\_\_\_\_ Is the employer contributing to your premium?  YES  NO  
 Relationship to Employee/Member:  Self  Adult Child  Parent (includes in-laws)  
 Spouse or Domestic Partner\*  Retiree  Grandparent (includes in-laws)

**PART A INSURABILITY QUESTIONS** (Please ask your prospect these questions BEFORE submitting this form.)**If you have any doubt about your answers, ask your doctor.**

1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Transient Ischemic Attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<b>TIA within the past [2 years]</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Organic brain syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>
		Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
		Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
		Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
		Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>
		Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated <b>within the past [12 months]</b> (except basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
		Diabetes with complications (e.g. amputation, kidney disease, eye disease, nerve disease); and/or diabetes combined with heart attack, bypass surgery, angina and/or TIA	<input type="checkbox"/>	<input type="checkbox"/>
		Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?  YES  NO3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?  YES  NO4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?  YES  NO5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?  YES  NO[6. Within the past [2 years], have you had an application for MetLife Long-Term Care Insurance declined, postponed or rated less than standard?]  YES  NO**IF YES was answered to any of Part A, questions 1–5, PLEASE DO NOT CONTINUE.**  
We regret that we can not offer Long-Term Care Insurance coverage in this situation.**PART B PROSPECT INFORMATION** Married or Domestic Partner\*  Single/Divorced/Widowed [QuikMet Order Ticket No. \_\_\_\_\_]

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Client Account No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  FemalePreferred Contact Phone No. \_\_\_\_\_ Additional Phone No. \_\_\_\_\_  
mm/dd/yyyyBest time to call  Morning  Afternoon  Evening

Primary Care Physician Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is a Spouse or any other member of the prospect's household applying for or do they already have a MetLife Long-Term Care Insurance policy?  YES  NO IF YES complete below.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

\*\*"Domestic Partner" means each of two people: (1) 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 (2) who meet the following requirements: (a) each person is 18 years of age or older; (b) neither person is married; (c) they share the same residence; (d) they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and (e) they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations and such commitment is expected to last indefinitely.

**Please attach any additional comments on a separate sheet.**

Select either Simple Advantage **OR** Custom Advantage

**Simple Advantage** (Only available to applicants age 61 and under.)

**STEP 1 – Select the Maximum Amount of Initial Coverage you want:** (Select one box)

This plan includes Guaranteed Purchase Option Rider.  
 [(For Simplified Underwriting, selection can not exceed \$300K.)]

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT					
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K
\$3K	<input type="checkbox"/>	–				
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

- Shared Care Rider\*                     
  Nonforfeiture Coverage Rider                     
  Cash Benefit Rider

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

**OR**

**Custom Advantage**

**STEP 1 – Select the Maximum Amount of Coverage you want:** (Select one box)

(For Simplified Underwriting, selection can not exceed [\$9K Monthly Benefit Amount or \$500K Total Benefit Amount].)

MONTHLY BENEFIT AMOUNT	TOTAL BENEFIT AMOUNT							
	\$75K	\$100K	\$200K	\$300K	\$400K	\$500K	\$1MM	
\$3K	<input type="checkbox"/>	–	–					
\$6K	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	–	
\$9K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
\$12K	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
\$15K	–	–	–	–	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**STEP 2 – Decide whether you want any of the [3] optional benefit riders:**

- Shared Care Rider\*                     
  Nonforfeiture Coverage Rider                     
  Cash Benefit Rider\*\*

[\* Available to Spouses or Domestic Partners who are applying for identical coverage.]

[\*\* Not available with \$1MM Total Benefit Amount.]

**STEP 3 – Select a Benefit Increase option:** (Select one box)

- Future Purchase Rider                     
  5% Automatic Compound Inflation Protection Rider  
 3% Automatic Compound Inflation Protection Rider                     
  I do not choose a Benefit Increase option.

**PART D**

**PAYMENT SELECTIONS**

**[1. Choose only ONE Premium Payment Option:**

- Standard
- Ten Year Premium Payment Rider\*

\*Not available with Simple Advantage or the Future Purchase Rider.

\*If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.

\*If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]

**2. Choose only ONE of the payment methods below.**

Please note there is an additional cost if you pay premiums more frequently than annually.

- a)  Employer List Bill/Payroll Deduction

This option may only be selected if available through your employer, and then is only open to employees [and their Spouses or Domestic Partners]. Deduction will be made from the payroll of the employee. [Employee must sign this authorization even if application is for Spouse or Domestic Partner.]

**Authorization:** I authorize the required premium for the coverage level selected to be deducted from my pay.

**X** \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of Employee (if any portion of the premium is to be payroll deducted) Date  
 Note: If premium is 100% employer funded, please write "100% Employer Paid" above.

- b)  Annual Direct Bill
- Semi-Annual Direct Bill
- Quarterly Direct Bill
- Monthly Direct Bill

**If you would like your bill sent to an address other than the address listed in Part B, please indicate below.**

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- [c]  Monthly Automatic Checking Account Deduction

**Electronic Payment Agreement Authorization**

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

Credit Union Phone Number ( ) \_\_\_\_\_

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

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

**X** \_\_\_\_\_ ]  
 Signature of Account Holder Date



**PART C****COVERAGE SELECTIONS****1 – Select Your Plan of Coverage:**

Value       Ideal       Premier       Facilities-Only]

**2 – Select Your Maximum Nursing Home Daily Benefit Amount (“DBA”):**

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

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

730 (2-year)       1,095 (3-year)       1,460 (4-year)  
 1,825 (5-year)       2,190 (6-year)       2,555 (7-year)]

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

100%       75%       50%]

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

\* **For Ideal:** Home Care paid at this percentage of the DBA.

**[\*For Premier:** Basic Daily Benefit paid at this percentage of the DBA.]

**5 – Select an Elimination Period:**

20 Days       45 Days       100 Days]

**6 – Select Optional Riders:**

**[Choose ONE Enhanced Elimination Period Option if desired.**

- Calendar Day Rider (Not available with Premier or Facilities Only)  
 Home Care EP Waiver (Not available with Premier or Facilities Only)

**Choose Benefit Riders as desired.**

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

**7 – Benefit Increase Options** (Choose one)

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

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

**8 – Nonforfeiture Coverage Rider:**

I select Nonforfeiture Coverage Rider     YES     NO



**LTC Insurance Preliminary Request Form**

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

Multi-Life Group # \_\_\_\_\_ Is the employer contributing to your premium?  YES  NO  
 Relationship to Employee/Member:  Self  Adult Child  Parent (includes in-laws)  
 Spouse or Domestic Partner\*  Retiree  Grandparent (includes in-laws)]

**PART A INSURABILITY QUESTIONS** (Please ask your prospect these questions BEFORE submitting this form.)

**If you have any doubt about your answers, ask your doctor.**

1. Have you ever had, do you currently have, have you been medically diagnosed as having, or have you been treated for:

YES	NO		YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (CVA)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Transient Ischemic Attacks (TIA's)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<b>TIA within the past [2 years]</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Dementia / Organic brain syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Memory loss and/or persistent forgetfulness that is progressive or treated with prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>
		Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
		Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
		Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
		Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>
		Cancer that has spread to another area of your body, including nodes; or cancer diagnosed or treated <b>within the past [12 months]</b> (except basal or squamous cell of the skin)	<input type="checkbox"/>	<input type="checkbox"/>
		Diabetes with complications (e.g. amputation, kidney disease, eye disease, nerve disease); and/or diabetes combined with heart attack, bypass surgery, angina and/or TIA	<input type="checkbox"/>	<input type="checkbox"/>
		Organ transplant completed or medically advised	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you been medically diagnosed as having or have you been treated for AIDS (Acquired Immune Deficiency Syndrome)/AIDS related conditions; or have you tested positive for antibodies to the AIDS virus?  YES  NO

3. Do you require supervision or human assistance with: bathing; dressing; eating; walking; getting in/out of bed or a chair; use of toilet; or bowel/bladder control?  YES  NO

4. Do you use or have you been advised to use any of the following medical equipment: wheelchair; motorized scooter; walker; stair lift; quad cane; crutches; dialysis; or oxygen (except for sleep apnea)?  YES  NO

5. Do you currently reside in, or have you been advised to enter or use: a nursing home; an assisted living facility; residential care facility; adult day care; any other type of long-term care facility; or home health care services?  YES  NO

[6. **Within the past [2 years]**, have you had an application for MetLife Long-Term Care Insurance declined, postponed or rated less than standard?  YES  NO

**IF YES was answered to any of Part A, questions 1–5, PLEASE DO NOT CONTINUE.**  
We regret that we can not offer Long-Term Care Insurance coverage in this situation.

**PART B PROSPECT INFORMATION**

Married or Domestic Partner\*  Single/Divorced/Widowed [QuikMet Order Ticket No. \_\_\_\_\_]

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Client Account No. \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
mm/dd/yyyy

Preferred Contact Phone No. \_\_\_\_\_ Additional Phone No. \_\_\_\_\_

Best time to call  Morning  Afternoon  Evening

Primary Care Physician Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Is a Spouse or any other member of the prospect's household applying for or do they already have a MetLife Long-Term Care Insurance policy?  YES  NO **IF YES** complete below.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ [Social Security No. \_\_\_\_\_]

\*"Domestic Partner" means each of two people: (1) 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 (2) who meet the following requirements: (a) each person is 18 years of age or older; (b) neither person is married; (c) they share the same residence; (d) they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside; and (e) they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations and such commitment is expected to last indefinitely.

**Please attach any additional comments on a separate sheet.**

**PART C****COVERAGE SELECTIONS****1 – Select Your Plan of Coverage:**

Value       Ideal       Premier       Facilities-Only]

**2 – Select Your Maximum Nursing Home Daily Benefit Amount (“DBA”):**

DBA: \$ \_\_\_\_\_ (\$50 to \$400\* per day in \$10 increments)

\* For Simplified Underwriting, DBA cannot exceed [\$300] per day.

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

730 (2-year)       1,095 (3-year)       1,460 (4-year)  
 1,825 (5-year)       2,190 (6-year)\*       2,555 (7-year)\*

\* For Simplified Underwriting Benefit Period cannot exceed 5 years.]

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

100%       75%       50%]

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

\* **For Ideal:** Home Care paid at this percentage of the DBA.

**[\*For Premier:** Basic Daily Benefit paid at this percentage of the DBA.]

**5 – Select an Elimination Period:**

20 Days       45 Days       100 Days]

**6 – Select Optional Riders:**

**[Choose ONE Enhanced Elimination Period Option if desired.**

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

**Choose Benefit Riders as desired.**

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

**7 – Benefit Increase Options** (Choose one)

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

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

**8 – Nonforfeiture Coverage Rider:**

I select Nonforfeiture Coverage Rider     YES     NO

**PART D**

**PAYMENT SELECTIONS**

**[1. Choose Standard Mode OR one of the Accelerated Payment Riders:**

Standard Mode

**Accelerated Payment Riders\*:**

Double Pay First Year Rider

Reduced Pay at Age 65 Rider

Paid-Up Premiums Rider

Ten Year Premium Payment Rider\*\*

\*Not available with Future Purchase Rider.

\*\*If premium payments under this option end before coverage is paid-up, and premium payment method is switched to standard, no offset, adjustment or refund of the accelerated premium paid under this option will be made.

\*\*If this payment option is selected, no further increases to coverage may be made once the policy is paid-up.]

**2. Choose only ONE of the payment methods below.**

Please note there is an additional cost if you pay premiums more frequently than annually.

a)  Employer List Bill/Payroll Deduction

This option may only be selected if available through your employer, and then is only open to employees [and their Spouses or Domestic Partners]. Deduction will be made from the payroll of the employee. [Employee must sign this authorization even if application is for Spouse or Domestic Partner.]

**Authorization:** I authorize the required premium for the coverage level selected to be deducted from my pay.

**X** \_\_\_\_\_

Signature of Employee (if any portion of the premium is to be payroll deducted)

\_\_\_\_\_ Date

Note: If premium is 100% employer funded, please write "100% Employer Paid" above.

b)  Annual Direct Bill

Semi-Annual Direct Bill

Quarterly Direct Bill

Monthly Direct Bill

**If you would like your bill sent to an address other than the address listed in Part A, please indicate below.**

Name \_\_\_\_\_ Phone Number ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

[c)  Monthly Automatic Checking Account Deduction

**Electronic Payment Agreement Authorization**

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

**Enclose a voided blank check for the account you wish to use. DO NOT send deposit slips. We will default your premium mode to quarterly direct bill if a voided check is not provided.** If using a credit union account, please provide credit union phone number.

Credit Union Phone Number ( ) \_\_\_\_\_

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

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

**X** \_\_\_\_\_ ]

Signature of Account Holder

\_\_\_\_\_ Date

# CONDITIONAL PREMIUM RECEIPT

**[EMPLOYER LIST BILL/PAYROLL DEDUCTION PARTICIPANTS ARE NOT ELIGIBLE FOR CONDITIONAL PREMIUM RECEIPT.]**

Received from _____ Name of <b>[APPLICANT A]</b> (Please print)	[Received from _____ Name of <b>APPLICANT B</b> (Please print)
\$ _____ on _____ Check No. _____ Amount Date	\$ _____ on _____ Check No. _____ ] Amount Date

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

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

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

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

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

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

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

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

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

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

*Gwenn L. Carr*

[Gwenn L. Carr, Senior Vice-President and Secretary, Metropolitan Life Insurance Company]

MetLife makes no representations as to the tax consequences of premium paid under this Receipt or the Benefits you receive under this Receipt. Consult your own legal or tax advisor. **ALL CHECKS MUST BE MADE PAYABLE TO METROPOLITAN LIFE INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT/PRODUCER OR LEAVE THE PAYEE BLANK.**

**LONG-TERM CARE INSURANCE PERSONAL WORKSHEET**

People buy Long-Term Care Insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they receive. Others don't want their family to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

**PREMIUM INFORMATION**

Policy Form Number: [LTC2007 Policy Series]

The premium for the coverage you are considering will be:

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

**[APPLICANT A]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually

**[APPLICANT B]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually]

**Type of Policy:** Guaranteed Renewable

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

**Rate Increase History:** [The company has sold long-term care insurance since 1986 and has sold this policy series since 2007. In 2009, MetLife applied a new premium rate schedule to individual long-term care insurance policy forms currently for sale in this and other states, where approved. Please note: The new premium rate schedules do not apply to any coverage that was in place prior to implementation of the new premium rates in that state. Your Agent/Producer can provide you with up-to-date information concerning the status of the approval of these new premium rate schedules in your particular state.

With respect to policies which have already been sold, MetLife has only increased its rates for long-term care insurance covering residents of a Continuing Care Retirement Community (CCRC), the details of which appear in the chart below:

Policy Form	Years Available	Year(s) of Increase	Percentage of Increase
#G.9873	1989-98	1999	9-38%

**QUESTIONS RELATED TO YOUR INCOME**

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

**[APPLICANT A]**  From my income  From my savings/investments  My family will pay

**[APPLICANT B]**  From my income  From my savings/investments  My family will pay]

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

**[APPLICANT A]**  Yes  No

**[APPLICANT B]**  Yes  No]

**What is your annual income?** (check one)

**[APPLICANT A]**  Under \$10,000  \$10,000 - \$19,999  \$20,000 - \$29,999  \$30,000 - \$50,000  Over \$50,000

**[APPLICANT B]**  Under \$10,000  \$10,000 - \$19,999  \$20,000 - \$29,999  \$30,000 - \$50,000  Over \$50,000]

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

**[APPLICANT A]**  No change  Increase  Decrease

**[APPLICANT B]**  No change  Increase  Decrease]

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

**Will you buy inflation protection?** (check one)

**[APPLICANT A]**  Yes  No

**[APPLICANT B]**  Yes  No]

## LONG-TERM CARE INSURANCE PERSONAL WORKSHEET – *continued*

### QUESTIONS RELATED TO YOUR INCOME (Continued)

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

**[APPLICANT A]**  From my income     From my savings/investments     My family will pay

**[APPLICANT B]**  From my income     From my savings/investments     My family will pay]

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

What elimination period are you considering?

**[APPLICANT A]**   [100]   Number of days                      \$ \_\_\_\_\_ Approximate cost for that period of care

**[APPLICANT B]**   [100]   Number of days                      \$ \_\_\_\_\_ Approximate cost for that period of care]

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

**[APPLICANT A]**  From my income     From my savings/investments     My family will pay

**[APPLICANT B]**  From my income     From my savings/investments     My family will pay]

### QUESTIONS RELATED TO YOUR SAVINGS/INVESTMENTS

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

**[APPLICANT A]**  Under \$20,000     \$20,000 - \$29,999     \$30,000 - \$50,000     Over \$50,000

**[APPLICANT B]**  Under \$20,000     \$20,000 - \$29,999     \$30,000 - \$50,000     Over \$50,000]

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

**[APPLICANT A]**  Stay about the same     Increase     Decrease

**[APPLICANT B]**  Stay about the same     Increase     Decrease]

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

## DISCLOSURE STATEMENT

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

The company may contact you to verify your answers.

**LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM**

**PREMIUM RATE** The following premium rate is applicable to you and will be in effect until a request for an increase is made and is filed (and approved in those states that require approval) by your state Insurance Department: (choose one)

**[APPLICANT A]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually

**[APPLICANT B]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually]

The premium for this policy will be shown on the schedule of benefits page of your policy.

**RATE SCHEDULE ADJUSTMENTS** Premium rate or rate schedule adjustments will be effective the first billing date that occurs on or after [45] days following notification of a rate adjustment.

**POTENTIAL RATE REVISION** This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can not be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase as a nonforfeiture coverage rider for an additional premium.)
- Exercise your contingent nonforfeiture rights.\* (This option may be available if you do not purchase the Nonforfeiture Coverage Rider, or if you purchase the Nonforfeiture Coverage Rider and it does not apply.)

**\*Contingent Nonforfeiture** If the premium rate for your policy goes up in the future and you didn't buy the Nonforfeiture Coverage Rider, or the Nonforfeiture Coverage Rider does not apply, you may be eligible for contingent nonforfeiture (referred to as "Contingent Benefit Upon Lapse" in the policy). Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e. new Total Benefit Amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining Total Benefit Amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining Total Benefit Amount.

Except for this reduced Total Benefit Amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this contingent nonforfeiture option, your policy, with this reduced Total Benefit Amount, will be considered "paid-up" with no further premiums due.

**EXAMPLE**

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50% or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

**CONTINGENT NONFORFEITURE**

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture (*Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.*)

ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM
29 & under	200%	63	58%	73	34%	83	17%
30-34	190%	64	54%	74	32%	84	16%
35-39	170%	65	50%	75	30%	85	15%
40-44	150%	66	48%	76	28%	86	14%
45-49	130%	67	46%	77	26%	87	13%
50-54	110%	68	44%	78	24%	88	12%
55-59	90%	69	42%	79	22%	89	11%
60	70%	70	40%	80	20%	90 & over	10%
61	66%	71	38%	81	19%		
62	62%	72	36%	82	18%		

## LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM – *continued*

### CONTINGENT BENEFIT UPON LAPSE FOR TEN YEAR PREMIUM PAYMENT RIDER

If you select the Ten Year Premium Payment Rider, your policy will also include the Contingent Benefit Upon Lapse for Accelerated Payment Option Endorsement ("Endorsement"), which provides a contingent benefit upon lapse under the conditions described below. If your policy includes the Nonforfeiture Coverage Rider, and you trigger benefits under both the Endorsement and the Nonforfeiture Coverage Rider, you can choose either of the two benefits, but not both. If benefits under both the Endorsement and the contingent nonforfeiture benefit described above are triggered by the same increase, you can choose either of the two benefits, but not both.

You are eligible for the contingent benefit upon lapse under the Endorsement if your policy includes the Ten Year Premium Payment Rider when all three conditions shown below are met:

1. If you receive a premium rate increase and the premium you are required to pay after the increase exceeds your initial annual premium by the percentage shown in the chart below or more. (Please note that each change in coverage after your policy effective date will be treated separately for purposes of determining the initial annual premium).

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premium within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay. (Please note that each change in coverage after your policy effective date that causes your premium to increase will be treated separately for purposes of determining the ratio).

If you exercise this option, your coverage that meets the qualification requirements for contingent benefit upon lapse under the Endorsement will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- The Total Benefit Amount (lifetime maximum benefit amount) your reduced paid-up policy will provide can be determined by multiplying 90% of the Total Benefit Amount at the time the policy becomes paid-up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- The monthly benefit amount you purchased will also be adjusted by the same ratio.

For purposes of determining coverage that qualifies for reduced "paid-up" status under this contingent benefit upon lapse, premiums for the coverage in effect on your policy effective date and each increase in annual premium due to a change in coverage after that date will each be treated separately.

### EXAMPLE

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the Total Benefit Amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

**LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM**

**PREMIUM RATE** The following premium rate is applicable to you and will be in effect until a request for an increase is made and is filed (and approved in those states that require approval) by your state Insurance Department: (choose one)<sup>1</sup>

**[APPLICANT A]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually

**[APPLICANT B]**  \$ \_\_\_\_\_ per month, or  \$ \_\_\_\_\_ per quarter, or  \$ \_\_\_\_\_ semi-annually, or  \$ \_\_\_\_\_ annually]

The premium for this policy will be shown on the schedule of benefits page of your policy.

**RATE SCHEDULE ADJUSTMENTS** Premium rate or rate schedule adjustments will be effective the first billing date that occurs on or after [45] days following notification of a rate adjustment.

**POTENTIAL RATE REVISION** This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can not be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase as a nonforfeiture coverage rider for an additional premium.)
- Exercise your contingent nonforfeiture rights.\* (This option may be available if you do not purchase the Nonforfeiture Coverage Rider, or if you purchase the Nonforfeiture Coverage Rider and it does not apply.)

**\*Contingent Nonforfeiture** If the premium rate for your policy goes up in the future and you didn't buy the Nonforfeiture Coverage Rider, or the Nonforfeiture Coverage Rider does not apply, you may be eligible for contingent nonforfeiture (referred to as "Contingent Benefit Upon Lapse" in the policy). Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e. new Total Lifetime Benefit) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining Total Lifetime Benefit is less than the total amount of premiums you've paid, the amount of coverage will be that remaining Total Lifetime Benefit.

Except for this reduced Total Lifetime Benefit, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this contingent nonforfeiture option, your policy, with this reduced Total Lifetime Benefit, will be considered "paid-up" with no further premiums due.

**EXAMPLE**

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50% or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

**CONTINGENT NONFORFEITURE**

Cumulative Premium Increase over Initial Premium that qualifies for Contingent Nonforfeiture (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM	ISSUE AGE	% INCREASE OVER INITIAL PREMIUM
29 & under	200%	63	58%	73	34%	83	17%
30-34	190%	64	54%	74	32%	84	16%
35-39	170%	65	50%	75	30%	85	15%
40-44	150%	66	48%	76	28%	86	14%
45-49	130%	67	46%	77	26%	87	13%
50-54	110%	68	44%	78	24%	88	12%
55-59	90%	69	42%	79	22%	89	11%
60	70%	70	40%	80	20%	90 & over	10%
61	66%	71	38%	81	19%		
62	62%	72	36%	82	18%		

<sup>1</sup>Premium rate will vary if applicant chooses one of the following pay Riders: Double-Pay First Year Rider or the Reduced Pay at Age 65 Rider.

## LONG-TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM – *continued*

### CONTINGENT BENEFIT UPON LAPSE FOR TEN YEAR PREMIUM PAYMENT RIDER

If you select the Ten Year Premium Payment Rider or the Paid-Up Premiums Rider, your policy will also include the Contingent Benefit Upon Lapse for Accelerated Payment Option Endorsement ("Endorsement"), which provides a contingent benefit upon lapse under the conditions described below. If your policy includes the Nonforfeiture Coverage Rider, and you trigger benefits under both the Endorsement and the Nonforfeiture Coverage Rider, you can choose either of the two benefits, but not both. If benefits under both the Endorsement and the contingent nonforfeiture benefit described above are triggered by the same increase, you can choose either of the two benefits, but not both.

You are eligible for the contingent benefit upon lapse under the Endorsement if your policy includes the Ten Year Premium Payment Rider or Paid-Up Premiums Rider when all three conditions shown below are met:

1. If you receive a premium rate increase and the premium you are required to pay after the increase exceeds your initial annual premium by the percentage shown in the chart below or more. (Please note that each change in coverage after your policy effective date will be treated separately for purposes of determining the initial annual premium).

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premium within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay. (Please note that each change in coverage after your policy effective date that causes your premium to increase will be treated separately for purposes of determining the ratio).

If you exercise this option, your coverage that meets the qualification requirements for contingent benefit upon lapse under the Endorsement will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- The Total Lifetime Benefit (lifetime maximum benefit amount) your reduced paid-up policy will provide can be determined by multiplying 90% of the Total Lifetime Benefit at the time the policy becomes paid-up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- The monthly benefit amount you purchased will also be adjusted by the same ratio.

For purposes of determining coverage that qualifies for reduced "paid-up" status under this contingent benefit upon lapse, premiums for the coverage in effect on your policy effective date and each increase in annual premium due to a change in coverage after that date will each be treated separately.

#### EXAMPLE

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the Total Lifetime Benefit that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

*SERFF Tracking Number:*      *META-126162298*                      *State:*                      *Arkansas*  
*Filing Company:*              *Metropolitan Life Insurance Company.*              *State Tracking Number:*      *42473*  
*Company Tracking Number:*      *W09-6 BW (LW)*  
*TOI:*                      *LTC03I Individual Long Term Care*              *Sub-TOI:*                      *LTC03I.001 Qualified*  
*Product Name:*              *Individual Long-Term Care Insurance Application Filing*  
*Project Name/Number:*      *LSAAPP-IND/W09-6 BW*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: META-126162298 State: Arkansas  
 Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 42473  
 Company Tracking Number: W09-6 BW (LW)  
 TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
 Product Name: Individual Long-Term Care Insurance Application Filing  
 Project Name/Number: LSAAPP-IND/W09-6 BW

## Supporting Document Schedules

<b>Satisfied -Name:</b>	Flesch Certification	<b>Review Status:</b>	Approved	07/09/2009
<b>Comments:</b>				
<b>Attachments:</b>				
	ARCERTREAD.pdf			
	ARCERTREG19.pdf			
<b>Satisfied -Name:</b>	Application	<b>Review Status:</b>	Approved	07/09/2009
<b>Comments:</b>	The Application forms are attached under the Forms Schedule tab.			
<b>Bypassed -Name:</b>	Health - Actuarial Justification	<b>Review Status:</b>	Approved	07/09/2009
<b>Bypass Reason:</b>	Not Applicable for this type of filing.			
<b>Comments:</b>				
<b>Bypassed -Name:</b>	Outline of Coverage	<b>Review Status:</b>	Approved	07/09/2009
<b>Bypass Reason:</b>	Not Applicable for this type of filing.			
<b>Comments:</b>				
<b>Satisfied -Name:</b>	Family History Question with Health Questions	<b>Review Status:</b>	Approved	07/09/2009
<b>Comments:</b>	We have included a separate page which contains a question about Family History, which may be incorporated into and be included at the end of the Health Questions in forms LSAAPP-IND-AR, LSAAPP-ML-AR, VIP2APP-IND-AR, VIP2APP-ML-AR, and REINST-AR.			
<b>Attachment:</b>	Family History Question with Health Questions.pdf			

SERFF Tracking Number: META-126162298 State: Arkansas  
Filing Company: Metropolitan Life Insurance Company. State Tracking Number: 42473  
Company Tracking Number: W09-6 BW (LW)  
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified  
Product Name: Individual Long-Term Care Insurance Application Filing  
Project Name/Number: LSAAPP-IND/W09-6 BW

**Review Status:**  
**Satisfied -Name:** NAIC Transmittal Document Approved 07/09/2009  
**Comments:**  
Attached is the NAIC Transmittal Document.  
**Attachment:**  
L-A&H NAIC Transmittal Document 1-1-2009.pdf

**Review Status:**  
**Satisfied -Name:** Cover Letter Approved 07/09/2009  
**Comments:**  
Attached is the Cover Letter.  
**Attachment:**  
Filing Letter - Applications - LTC2007 & VIP2 - W09-6 BW.pdf

**Review Status:**  
**Satisfied -Name:** Amendment to Filing from Analyst Approved 07/09/2009  
**Comments:**  
Attached is an amendment to this filing from Analyst.  
**Attachment:**  
Amendment Note to Arkansas 2009-06-24.pdf



Metropolitan Life Insurance Company  
NAIC Company Number: 65978  
NAIC Group Number: 241

### ARKANSAS FLESCH CERTIFICATION

I certify that the form shown below has achieved the Flesch Reading Ease Score shown below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Form Description	Flesch Score
LSAAPP-IND-AR	Application	52.06
LSAAPP-ML-AR	Application	52.06
VIP2APP-IND-AR	Application	52.06
VIP2APP-ML-AR	Application	52.06
REINST-AR	Application	50.28
LSA-TAPP-IND	Preliminary Request Form	N/A
LSA-TAPP-ML	Preliminary Request Form	N/A
VIP2-TAPP-IND	Preliminary Request Form	N/A
VIP2-TAPP-ML	Preliminary Request Form	N/A
CPR10	Conditional Premium Receipt	50.78
PW10	Personal Worksheet	55.92
L-PRD10-10PAY	Rate Disclosure	51.08
V-PRD10-10PAY	Rate Disclosure	51.08

Herbert B. Brown Jr.  
Vice President



Metropolitan Life Insurance Company  
NAIC Company Number: 65978  
NAIC Group Number: 241

**ARKANSAS CERTIFICATION**  
**Rule and Regulation 19**  
**Unfair Sex Discrimination in the Sale of Insurance**

I certify that this submission meets the provisions of Rule and Regulation 19, and all applicable requirements of the Arkansas Department of Insurance.

A handwritten signature in black ink, appearing to read "Herbert B. Brown Jr.", written in a cursive style.

Herbert B. Brown Jr.  
Vice President

This section may or may not be included in the application. If included, it will appear at the end of the Health Questions section.

**PART [D]**

**HEALTH QUESTIONS – *continued***

**[FAMILY HISTORY:** Please provide the following medical history for your biological relatives. Include current medical conditions and age of onset that you know about.

**[APPLICANT A]**

Living Relatives	Current Age	Medical Condition(s) and Age of Onset	Deceased Relatives	Age at Death	Cause of Death
Father			Father		
Mother			Mother		
Brother(s)			Brother(s)		
Sister(s)			Sister(s)		

**[APPLICANT B]**

Living Relatives	Current Age	Medical Condition(s) and Age of Onset	Deceased Relatives	Age at Death	Cause of Death
Father			Father		
Mother			Mother		
Brother(s)			Brother(s)		
Sister(s)			Sister(s)		

## Life, Accident & Health, Annuity, Credit Transmittal Document

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Metropolitan Life Insurance Company Institutional Contracts 1095 Avenue of the Americas New York, NY 10036-6796	NY		241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	William D. Wilson Metropolitan Life Insurance Co. 501 Route 22 Bridgewater Twncsp, NJ 08807	(908) 253-2290	(908) 253-2126	wwilson@metlife.com

<b>5.</b>	<b>Requested Filing Mode</b>	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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<b>6.</b>	<b>Company Tracking Number</b>	W09-6 BW
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<b>7.</b>	<input checked="" type="checkbox"/> <b>New Submission</b> <input type="checkbox"/> <b>Resubmission</b>	Previous file # _____
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<b>8.</b>	<b>Market</b>	<input checked="" type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input type="checkbox"/> Large <input type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____
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<b>9.</b>	<b>Type of Insurance (TOI)</b>	LTC031 – Individual Long-Term Care Insurance
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<b>10.</b>	<b>Sub-Type of Insurance (Sub-TOI)</b>	LTC031.001 – Qualified
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<b>11.</b>	<b>Submitted Documents</b>	<input type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input checked="" type="checkbox"/> Rate Disclosure & Personal Worksheet <b>Rates</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreements <input type="checkbox"/> Statement of Variability <input checked="" type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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12.	<b>Filing Submission Date</b>	<b>May 22, 2009</b>	
13	<b>Filing Fee (If required)</b>	Amount <u>\$20.00 (SERFF EFT)</u>	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No	Check Number _____
14.	<b>Date of Domiciliary Approval</b>		
15.	<b>Filing Description:</b>		
<p style="text-align: center;"><b>This is a filing of individual long-term care application forms. Please see our filing letter for details concerning this filing.</b></p>			

16.	<b>Certification (If required)</b>		
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p>			
Print Name <u>Carolyn Roth</u>		Title <u>Director</u>	
Signature <u></u>		Date: <u>May 22, 2009</u>	

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		<b>W09-6 BW</b>
<b>This filing corresponds to rate filing company tracking number</b>		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Individual Application	LSAAPP-IND-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
02	Individual Application	VIP2APP-IND-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
03	Multi-Life Application	LSAAPP-ML-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
04	Multi-Life Application	VIP2APP-ML-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
05	Tele-Application	LSA-TAPP-IND	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
06	Tele-Application	VIP2-TAPP-IND	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
07	Multi-Life Tele-Application	LSA-TAP-ML	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
08	Multi-Life Tele-Application	VIP2-TAPP-ML	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
09	Reinstatement Application	REINST-AR	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Application			
10	Conditional Premium Receipt	CPR10	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Receipt			

11	<b>Personal Worksheet</b>	<b>PW10</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
	<b>Disclosure</b>			
12	<b>Rate Disclosure form</b>	<b>L-PRD10-10PAY</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
	<b>Disclosure</b>			
13	<b>Rate Disclosure Form</b>	<b>V-PRD10-10PAY</b>	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
	<b>Disclosure</b>			

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
03			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
04			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
05			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
06			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
07			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
08			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
09			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
10			<input type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	

LH RFA-1

Metropolitan Life Insurance Company  
Institutional Contracts – **MSC #39.087**  
1095 Avenue of the Americas  
New York, NY 10036-6796  
Tel 212 578-2944 Fax 212 578-6247  
[Croth@metlife.com](mailto:Croth@metlife.com)



**Carolyn J. Roth**  
Director  
Institutional Business Contracts

May 22, 2009

Arkansas Insurance Department  
1200 West 3rd Street  
Little Rock, Arkansas 72201-1904

Re: Individual Long-Term Care Insurance Application Filing  
Our NAIC Company No. is 65978  
Our FEIN is 13-5581829

Dear Sir/Madam:

The following individual long-term care insurance forms are submitted for your review and approval for use in your state. These forms are new and do not replace any forms previously filed with your Department.

<b>Form Number</b>	<b>Description</b>
LSAAPP-IND-AR	Application form for use by individuals applying for policy form LTC2007, approved by your Department on August 17, 2007.
LSAAPP-ML-AR	Multi-Life Application form for use by individuals applying for policy form LTC2007 under a multi-life arrangement sponsored by an employer or association. Individuals using this application will be employees of an employer or members of an association where the employer or association has entered into a "multi-life" arrangement with us. The application will also be available to family members of the employee or member to whom the multi-life arrangement applies.
VIP2APP-IND-AR	Application form for use by individuals applying for policy forms LTC2-IDEAL et al, approved by your Department on January 13, 2005.
VIP2APP-ML-AR	Multi-Life Application form for use by individuals applying for policy forms LTC2-IDEAL et al under a multi-life arrangement sponsored by an employer or association. Individuals using this application will be employees of an employer or members of an association where the employer or association has entered into a "multi-life" arrangement with us. The application will also be available to family members of the employee or member to whom the multi-life arrangement applies.
REINST-AR	Reinstatement application for use by individuals applying for reinstatement for policy form LTC2007 or policy forms LTC2-IDEAL et al.

Please note that we have included a separate page which contains a question about Family History, which may be incorporated into and be included at the end of the Health Questions in forms LSAAPP-IND-AR, LSAAPP-ML-AR, VIP2APP-IND-AR, VIP2APP-ML-AR, and REINST-AR. Text may appear as shown, or be omitted. Please note that while we are submitting the Family History question as a separate page, if we include the question, it will be directly incorporated into the applicable section of the application.

LSA-TAPP-IND	LTC Insurance Preliminary Request Form. Form that may be used for recording preliminary information provided by a prospective applicant prior to completing application form LSAAPP-IND-AR, included with this filing. When this form is used, the prospective applicant will be provided with a packet containing regulatory forms, including an Outline of Coverage. An application will subsequently be completed and signed by the insured.
LSA-TAPP-ML	LTC Insurance Preliminary Request Form. Form that may be used for recording preliminary information provided by a prospective applicant prior to completing application form LSAAPP-ML-AR, included with this filing. When this form is used, the prospective applicant will be provided with a packet containing regulatory forms, including an Outline of Coverage. An application will subsequently be completed and signed by the insured.
VIP2-TAPP-IND	LTC Insurance Preliminary Request Form. Form that may be used for recording preliminary information provided by a prospective applicant prior to completing application form VIP2APP-IND-AR, included with this filing. When this form is used, the prospective applicant will be provided with a packet containing regulatory forms, including an Outline of Coverage. An application will subsequently be completed and signed by the insured.
VIP2-TAPP-ML	LTC Insurance Preliminary Request Form. Form that may be used for recording preliminary information provided by a prospective applicant prior to completing application form VIP2APP-ML-AR, included with this filing. When this form is used, the prospective applicant will be provided with a packet containing regulatory forms, including an Outline of Coverage. An application will subsequently be completed and signed by the insured.
CPR10	Conditional Premium Receipt: For use by individuals applying for policy form LTC2007 or policy forms LTC2-IDEAL et al. If requirements set forth in the receipt are met, provides coverage from the application date. This form may be enclosed in a document package that will be provided to the applicant.
PW10	Personal Worksheet: For use by individuals applying for policy form LTC2007 or policy forms LTC2-IDEAL et al. This form may be enclosed in a document package that will be provided to the applicant. The section titled Rate Increase History will appear as shown or may vary: (1) to accurately reflect the facts that pertain to any premium rate schedule filing that is required to be disclosed in this section and to include any needed additional explanatory information relating to rate history; (2) to remove any of the listed rate increases at such point in time that the rate increase is no longer required to be shown; or (3) to include any new rate increase information that may be required to be added in the future.
L-PRD10-10PAY	Rate Disclosure Form: For use by individuals applying for policy form LTC2007. This form may be enclosed in a document package that will be provided to the applicant.
V-PRD10-10PAY	Rate Disclosure Form: For use by individuals applying for policy forms LTC2-IDEAL et al. This form may be enclosed in a document package that will be provided to the applicant.

**Variable Material**

The variable material contained in each of the filed forms is indicated by brackets.

**Filing Fees**

We enclose the required filing fee.

**Filing Correspondence Instructions**

Please address all correspondence regarding this filing as follows:

Metropolitan Life Insurance Company  
Institutional Contracts – MSC #39.087  
1095 Avenue of the Americas  
New York, NY 10036-6796

If you have any questions or comments that you feel could best be handled by contacting MetLife, please feel free to contact Bill Wilson via telephone (908-253-2290), fax (908-253-2126) or e-mail ([wwilson@metlife.com](mailto:wwilson@metlife.com)).

Thank you for your attention to our filing. We look forward to hearing from you.

Sincerely,



Carolyn Roth  
Director

**June 24, 2009**

**Amendment to SERFF TRACKING # META-126162298**

**Extension of Use with Previously Approved Forms**

We wish to extend the use of Application Amendment Forms LTC-APP-AMEND and LTC-GRO-APP-AMEND, approved by your Department on July 2, 2008, for use with the applications included in this submission.

Thank you