

SERFF Tracking Number: META-126840677 State: Arkansas
Filing Company: Metropolitan Life Insurance Company State Tracking Number: 46939
Company Tracking Number: NY10-13 KC (LW)
TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
Limited Benefit
Product Name: Group Accident and Health Insurance
Project Name/Number: GCERT10-CI series/NY10-13 KC

Filing at a Glance

Company: Metropolitan Life Insurance Company

Product Name: Group Accident and Health Insurance SERFF Tr Num: META-126840677 State: Arkansas

TOI: H07G Group Health - Specified Disease - Limited Benefit SERFF Status: Closed-Approved- Closed State Tr Num: 46939

Sub-TOI: H07G.001 Critical Illness Co Tr Num: NY10-13 KC (LW) State Status: Approved-Closed
Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Sandra Bennett, Ruth

Rivera, Linda Williams

Date Submitted: 09/30/2010

Disposition Date: 10/08/2010
Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: GCERT10-CI series
Project Number: NY10-13 KC
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/08/2010

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Employer, Trust, Other
Explanation for Other Group Market Type:
Union
State Status Changed: 10/08/2010
Created By: Linda Williams
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Linda Williams

Filing Description:

Metropolitan Life Insurance Company
1095 Avenue of the Americas, MSC 49042
New York, New York 10036
Tel 212-578-5954 Fax 212-578-3874
j david1@metlife.com

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Re: Group Accident & Health Insurance (see table of form numbers)
Our NAIC Company No. is 65978
Our FEIN is 13-5581829

Dear Sir/Madam:

We enclose for filing, final printed copies of the group accident and health insurance forms described below. A table of form numbers for the forms we are submitting is attached. These forms are intended to provide group critical illness coverage on a lump sum basis. These forms are new and do not replace any forms previously filed with the Department.

Form No.	Description
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GCERT10-CI series Group certificate series, providing critical illness insurance with a lump sum benefit. A single lump-sum benefit is paid once upon occurrence of a covered condition. Reoccurrences of the same covered condition may be covered, and single lump sum benefits may be payable for occurrences of other covered conditions. This certificate series will be issued to individuals who are insured under group policy series GPNP07-CI or GPNP09-CI, and will also be attached to GPNP07-CI or GPNP09-CI upon issuance of the policy, as an exhibit, to provide benefits under the policy.

The GCERT10-CI certificate forms have been developed and are being filed on an insert basis. We may, depending on the design of a particular group policyholder's plan, omit the following pages:

- GCERT10-CI-elig-dep
- GCERT10-CI-wopr
- GCERT10-CI-limit
- GCERT10-CI-wp
- GCERT10-CI-prex
- GCERT10-CI-dr2ml
- GCERT10-CI-port
- GCERT10-CI-coi-eport

The insurance described may be contributory or noncontributory depending on the specifications of the group policyholder. If coverage is contributory, the employees may pay all or part of the premium.

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GCERT10-CI series The certificate series includes a portability provision whereby, in certain specified situations, the employee will be entitled to coverage under another group policy if coverage ends under this certificate. We are in the process of creating a group portability policy and certificate to provide the continued coverage. Please be assured that the portability provision will not be issued until the portability policy and certificate are effective.

The variable material contained in the GCERT10-CI certificate series is indicated by brackets.

GEF10-CI Group Enrollment Form. The GEF10-CI enrollment form will be used by group members and their dependents who are requesting coverage under GCERT10-CI. The forms have been completed with hypothetical data. There is also variable material indicated by brackets.

GCERT10-CI-MOT Major Organ Transplant Rider. This rider will be used to provide a lump sum benefit for major organ transplant. The decision to include this rider will be made by the group policyholder as part of the plan design. Variable material in GCERT10-CI-MOT is indicated by brackets and varies in accordance with GCERT10-CI.

Extension of Use of Previously Approved Forms

We wish to extend the use of the following forms for use with the forms included in this filing:

Form	Description	Approval Date	SERFF or State Tracking Number
GPNP09-CI	Group Policy Form	1-8-2010	META-126423829
GPNP07-CI	Group Policy Form	2-8-2007	META-125078788
GAPP07-CI	Group Policy Application Form	2-8-2007	META-125078788
GPA07-CI	Group Policy Amendment Form	2-8-2007	META-125078788
CR07-CI	Group Certificate Rider Form	2-8-2007	META-125078788

Filing Fee

We enclose the required filing fee.

Actuarial Information

Enclosed is actuarial information in support of this filing. The enclosed information contains formulas, statistics, assumptions and other information that are proprietary trade secrets of MetLife. Disclosure of this information would cause substantial injury to MetLife's competitive position. Therefore, we request that the Department treat these

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LIST OF FORMS INCLUDED IN THIS SUBMISSION

Group Certificate Forms

GCERT10-CI-fp GCERT10-CI-bene-eb GCERT10-CI-term
GCERT10-CI-notice GCERT10-CI-bene-nci GCERT10-CI-dr2ml
GCERT10-CI-toc GCERT10-CI-wopr GCERT10-CI-port
GCERT10-CI-sched GCERT10-CI-excl/proof GCERT10-CI-coi-eport
GCERT10-CI-def GCERT10-CI-limit GCERT10-CI-claim
GCERT10-CI-elig-ee GCERT10-CI-wp GCERT10-CI-gen pro
GCERT10-CI-elig-dep GCERT10-CI-prex
GCERT10-CI-bene GCERT10-CI-exclu

Group Enrollment Form

GEF10-CI

Group Outline of Coverage

GOOC10-CI

Group Major Organ Transplant Rider

GCERT10-CI-MOT

Company and Contact

Filing Contact Information

John ("Jack") David, Mgr.-Contract Compliance jdavid1@metlife.com
LTC

MetLife 212-578-5954 [Phone]
1095 Avenue of the Americas 212-578-3874 [FAX]
New York, NY 10036-6796

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$150.00
 Retaliatory? No
 Fee Explanation: \$50.00 Per Form submitted for Approval.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Metropolitan Life Insurance Company	\$150.00	09/30/2010	40043895

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/08/2010	10/08/2010

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Supporting Document	NAIC Transmittal Document	Approved-Closed	Yes
Form	Certificate insert pages	Approved-Closed	Yes
Form	Group Enrollment Form	Approved-Closed	Yes
Form	Certificate Rider	Approved-Closed	Yes
Rate	Rate Pages	Approved-Closed	Yes

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Form Schedule

Lead Form Number: GCERT10-CI series

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/08/2010	GCERT10-CI	Certificate	Certificate insert Amendments, Insert Page, Endorsement or Rider	Initial		51.780	Group Certificate2.0 [GCERT10-CI][AR].pdf
Approved-Closed 10/08/2010	GEF10-CI	Application/Group Enrollment Form	Enrollment Form	Initial		51.400	Enrollment form [AR][with John Doe].pdf
Approved-Closed 10/08/2010	GCERT10-CI-MOT	Certificate	Certificate Rider Amendments, Insert Page, Endorsement or Rider	Initial		51.890	MAJOR ORGAN TRANSPLANT RIDER-FINAL.pdf



METROPOLITAN LIFE INSURANCE COMPANY
[200 PARK AVENUE, NEW YORK], NEW YORK [10166-0188]

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You [and Your Dependents] are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. This Certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	[Any Company]
Group Policy Number:	[XXXXXXXXXX]
[Employee Name:	[John Doe]
Employee Number:	12345678
Effective Date of Insurance:	December 1, 2010]
MetLife Toll Free Number(s):	
[For Claim Information	1-800-XXX-YYYY
For General Information	1-800-XXX-YYYY]
[MetLife Email Address	www.metlife.com]

[We have issued this Certificate to You in consideration of the payment of the [Contribution] [and the statements made in Your Enrollment Form. Your Enrollment Form is part of Your Certificate].]

[Notice to Buyer: This is a critical illness insurance Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and submission of Proof of a Covered Condition, this Certificate provides a limited benefit in the event You are Diagnosed with certain specified diseases, or have certain surgical procedures performed. Benefits provided are a supplement, and not a substitute for, Medical Coverage. You should have Medical Coverage when You enroll for this insurance.]

[WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICES(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.]

[NOTICE FOR RESIDENTS OF ARKANSAS

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

(888) 232-0581

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

**ARKANSAS INSURANCE DEPARTMENT
1200 WEST THIRD STREET
LITTLE ROCK, ARKANSAS 72201]**

(800) 852-5494 or (501) 371-2640]

TABLE OF CONTENTS

Section	Page
[NOTICE FOR RESIDENTS OF ARKANSAS.....	2
SCHEDULE OF INSURANCE.....	5
DEFINITIONS.....	7
ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.....	16
Eligible Classes.....	16
Date You Are Eligible For Insurance.....	16
Enrollment Process.....	16
Date Your Insurance Takes Effect.....	16
Benefit Increases.....	16
ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE.....	17
Eligible Classes For Dependent Insurance.....	17
Date You Are Eligible For Dependent Insurance.....	17
Enrollment Process.....	17
Date Dependent Insurance Takes Effect.....	17
Benefit Increases.....	18
CRITICAL ILLNESS BENEFITS FOR ALZHEIMER’S DISEASE, CORONARY ARTERY BYPASS GRAFT, FULL BENEFIT CANCER, HEART ATTACK, KIDNEY FAILURE, AND STROKE.....	19
CRITICAL ILLNESS BENEFITS FOR PARTIAL BENEFIT CANCER AND LISTED CONDITIONS.....	19
RE-OCCURRENCE BENEFIT.....	20
Reduction on Account of Prior Claims Paid.....	20
Health Screening Benefit.....	21
Lodging Benefit.....	23
Transportation Benefit.....	23
Evaluation Benefit.....	24
NCI Cancer Center Benefit.....	25
Waiver Of Premiums.....	26
Exclusions that Apply to Specific Covered Conditions.....	28
Additional Proof Requirements for Each Covered Condition.....	30
LIMITATIONS.....	32
Benefit Reduction Due to Age.....	32
Waiting Period.....	33
PREEXISTING CONDITION EXCLUSION.....	34
OTHER EXCLUSIONS.....	35
Exclusion for Intoxication.....	35
General Exclusions.....	35
WHEN INSURANCE ENDS.....	36
Date Your Insurance Ends.....	36
Date Dependent Insurance Ends.....	36
SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER GROUP CRITICAL ILLNESS INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER.....	37
PORTABILITY OF COVERAGE.....	38
Request Period.....	38
Premiums for the New Certificate.....	38
CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.....	39
For Mentally Or Physically Handicapped Children.....	39
For Family And Medical Leave.....	39
[At The Group Policyholder’s Option.....	39
AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT.....	40
Request Period.....	40
Premiums for Continued Insurance.....	40
End of Continued Insurance.....	41

TABLE OF CONTENTS

Section	Page
CLAIMS	42
Filing A Claim	42
Payment Of Benefits	42
Authorizations	43
Examinations.....	43
Autopsy	43
Time Limit on Legal Actions	43
GENERAL PROVISIONS	44
Changes in Standards.....	44
Entire Contract	44
[Incontestability: Statements Made By You	44
Misstatements	44
Assignment.....	44
Conformity with Law	44

SCHEDULE OF INSURANCE

[This schedule shows the benefits that You have selected under the Group Policy. You and Your Dependents will only be insured for benefits:

- for which You and Your Dependents become and remain eligible; and
- which are in effect under the Group Policy and this Certificate.

BENEFIT AMOUNT

For You	[\$1,000 - \$500,000]
For Your Spouse or Domestic Partner	[\$1,000 - \$500,000]
For Your Dependent Child	[\$1,000 - \$500,000]

TOTAL BENEFIT AMOUNT

For You	[\$2,000 - \$1,000,000]*
For Your Spouse or Domestic Partner	[\$2,000 - \$1,000,000]*
For Your Dependent Child	[\$2,000 - \$1,000,000]

*BENEFIT REDUCTION DUE TO AGE

The Benefit Amount for You is reduced to:

- **[\$750 - \$375,000]** on the first of the month coincident with or next following the date You reach age 65; and
- **[\$500 - \$250,000]** on the first of the month coincident with or next following the date You reach age 70.

The Total Benefit Amount for You is reduced to:

- **[\$1,500 - \$750,000]** on the first of the month coincident with or next following the date You reach age 65; and
- **[\$1,000 - \$500,000]** on the first of the month coincident with or next following the date You reach age 70.

The Benefit Amount for Your Spouse or Domestic Partner is reduced to:

- **[\$750 - \$375,000]** on the first of the month coincident with or next following the date Your Spouse or Domestic Partner reaches age 65; and
- **[\$500 - \$250,000]** on the first of the month coincident with or next following the date Your Spouse or Domestic Partner reaches age 70.

The Total Benefit Amount for Your Spouse or Domestic Partner is reduced to:

- **[\$1,500 - \$750,000]** on the first of the month coincident with or next following the date Your Spouse or Domestic Partner reaches age 65; and
- **[\$1,000 - \$500,000]** on the first of the month coincident with or next following the date Your Spouse or Domestic Partner reaches age 70.

*Please see the *Benefit Reduction Due to Age* provision.

SCHEDULE OF INSURANCE (continued)

BENEFITS FOR COVERED CONDITIONS

<u>Covered Condition</u>	<u>Initial Benefit</u>	<u>Re-Occurrence Benefit</u>
Alzheimer's Disease	100% of Benefit Amount	NONE
Coronary Artery Bypass Graft	100% of Benefit Amount	50% of Benefit Amount
Full Benefit Cancer	100% of Benefit Amount	50% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	12.5% of Benefit Amount
Heart Attack	100% of Benefit Amount	50% of Benefit Amount
Kidney Failure	100% of Benefit Amount	NONE
Stroke	100% of Benefit Amount	50% of Benefit Amount
Any one of Listed Conditions	25% of Benefit Amount	[NONE]**]

[**There may be a Re-Occurrence Benefit for an Occurrence of rabies. Please see the RE-OCCURRENCE BENEFIT section of this Certificate for details.]

[Waiting Period: [30-90] days for Partial Benefit Cancer and Full Benefit Cancer
30 days for all other Covered Conditions]]

IMPORTANT NOTE: This Certificate contains certain Proof requirements, exclusions, limitations and other provisions that may reduce benefits or prevent [a Covered Person] from receiving any benefits under this Certificate. PLEASE READ YOUR ENTIRE CERTIFICATE CAREFULLY.

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

[Actively at Work or Active Work] means [that You are performing all of the usual and customary duties of Your job [on a Full-Time or a Part-Time basis]. This must be done at:

- [the Group Policyholder's] place of business;
- an alternate place approved by [the Group Policyholder]; or
- a place to which [the Group Policyholder's] business requires You to travel.

You will be deemed to be Actively at Work during weekends or [Group Policyholder] approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.]]

[Activities of Daily Living] means any of the following:

- Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- Transferring: moving into or out of a bed, chair or wheelchair,
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene.
- Continence: ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.]

Alzheimer's Disease means the development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

Benefit Amount the amount We use to determine the benefit payable for a Covered Condition.

Benefit Increase means a simultaneous increase in both the Benefit Amount and Total Benefit Amount.

Benefit Suspension Period means the [180-365] day period following the date a Covered Condition, for which this Certificate pays a benefit, Occurs [with respect to a Covered Person].

Board Certified means a Physician has received certification in the appropriate medical specialty by [a member board of the American Board of Medical Specialties].

Certificate means this Certificate including any riders attached to it.

DEFINITIONS (continued)

Clinical Diagnosis means a Diagnosis of Partial Benefit Cancer or Full Benefit Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Partial Benefit Cancer or Full Benefit Cancer only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician who is a Board Certified oncologist is treating [the Covered Person] for Partial Benefit Cancer or Full Benefit Cancer.

[**Contribution** means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.]

Coronary Artery Bypass Graft means the undergoing of open heart Surgery performed by a Physician who is a Board Certified cardiothoracic surgeon to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. The procedure must be deemed medically necessary by a Physician who is a Board Certified cardiologist, and be supported by pre-operative angiographic evidence. Coronary Artery Bypass Graft does not include:

- angioplasty (percutaneous transluminal coronary angioplasty);
- laser relief;
- stent insertion;
- coronary angiography; or
- any other intra-catheter technique.

Covered Condition means the following, as they are defined in this Certificate:

- Alzheimer's Disease;
- Coronary Artery Bypass Graft;
- Full Benefit Cancer;
- Partial Benefit Cancer;
- Heart Attack;
- Kidney Failure;
- Stroke; or
- any of the Listed Conditions.

[**Covered Person** means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.]

[**Dependent** means Your Spouse, Domestic Partner and/or Dependent Child.]

DEFINITIONS (continued)

[Dependent Child means the following:

Your biological, adopted, or step child who is [at least **[1-15]** days old,] under age **[18-26]**, unmarried and supported by You; and

Your biological, adopted or stepchild between ages **[18-25]** and **[19-26]** who is:

- unmarried;
- supported by You;
- not employed on a full-time basis; and
- a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located.

The term does not include an unborn or stillborn child, or any person who;

- is serving in the armed forces, or any auxiliary units of the armed forces, of any country;
- lives outside of the United States for more than **[6-48]** consecutive months; or
- is insured under the Group Policy as an employee.

A Dependent Child cannot be insured as a Dependent Child of more than one employee under the Group Policy. Your adopted child will not be a Dependent Child prior to the date the child is placed in Your home for adoption.]

[Dependent Insurance means insurance under this Certificate for Your Dependents.]

Diagnosis means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings.

Diagnose means the act of making a Diagnosis.

[Disabled or Disability means that, solely due to a Covered Condition for which We have paid a benefit under this Certificate:

- while You are unemployed, You become and remain continuously unable to perform two or more Activities of Daily Living; or
- while You are employed, You become and remain continuously unable to perform any work for pay or benefits for which You are or become reasonably fitted by Your education, training or experience.]

DEFINITIONS (continued)

[Domestic Partner means each of two people, one of whom is an employee of the Group Policyholder, who:

1. have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 - 18 years of age or older;
 - unmarried;
 - the sole domestic partner of the other;
 - sharing a primary residence with the other;
 - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and signed by the employee.

The term "Domestic Partner" does not include any person who:

- is serving in the armed forces, or any auxiliary units of the armed forces, of any country; or
- lives outside the United States for more than **[6-48]** consecutive months.

No person can be insured under the Group Policy as both an employee and as a Domestic Partner.]

[Enrollment Form means the Written form provided by Us that You use to enroll for insurance under the Group Policy, including any amendments thereto.]

First Occurs or **First Occurrence** means, with respect to a Covered Condition, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs.

Full Benefit Cancer means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue provided that a Physician who is Board Certified in the medical specialty that is appropriate for the type of cancer involved has determined that:

- Surgery, radiotherapy, or chemotherapy is medically necessary;
- there is metastasis; or
- the patient has terminal cancer, is expected to die within 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

[Full-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.]

Geriatrician means a Physician specializing in the assessment and treatment of elderly people. The Physician must be Board Certified in geriatric medicine by the American Board of Geriatric Medicine.

Group Policy means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

Group Policyholder means [the employer named on the first page of this Certificate.]

DEFINITIONS (continued)

Heart Attack (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

[Hospital means a short-term, acute care, general facility which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Hospitalized means:

- admission for inpatient care in a Hospital;
- receipt of care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receipt of the following treatment, wherever performed:
 - chemotherapy;
 - radiation therapy; or
 - dialysis.]

Initial Benefit means the benefit, as specified in the Schedule of Insurance, that We will pay for:

- any one of the Listed Conditions that First Occurs while coverage is in effect under this Certificate; and
- each of the following Covered Conditions which First Occurs while coverage is in effect under this Certificate: Alzheimer's Disease; Coronary Artery Bypass Graft; Full Benefit Cancer; Partial Benefit Cancer; Heart Attack; Kidney Failure; and Stroke.

Kidney Failure means the total, end stage, irreversible failure of both kidneys to function, provided that a Physician who is a Board Certified nephrologist has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

DEFINITIONS (continued)

Listed Conditions means any of the following diseases:

- Addison's disease (adrenal hypofunction);
- amyotrophic lateral sclerosis (Lou Gehrig's disease);
- cerebrospinal meningitis (bacterial);
- cerebral palsy;
- cystic fibrosis;
- diphtheria;
- encephalitis;
- Huntington's disease (Huntington's chorea);
- Legionnaire's disease;
- malaria;
- multiple sclerosis (definitive diagnosis);
- muscular dystrophy;
- myasthenia gravis;
- necrotizing fasciitis;
- osteomyelitis;
- poliomyelitis;
- rabies;
- sickle cell anemia (excluding sickle cell trait);
- systemic lupus erythematosus (SLE);
- systemic sclerosis (scleroderma);
- tetanus; and
- tuberculosis.

[**Lodging** means an establishment licensed under the laws where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee.]

Maximum Benefit Amount means the maximum amount of benefits for which an individual in an eligible class can apply under the Group Policy.

Medical Coverage means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing benefits for hospital, surgical and medical expenses or treatment. Medical Coverage does not include Medicaid.

Neurologist means a Physician who specializes in the diagnosis and treatment of disorders of the nervous system and who is Board Certified by the American Board of Psychiatry and Neurology, Inc.

Neuropsychologist means a psychologist who has completed special training in the neurological causes of brain disorders and who specializes in diagnosing and treating these illnesses using a predominantly medical approach and is Board Certified by the American Board of Professional Neuropsychology.

DEFINITIONS (continued)

Occurs or Occurrence means:

- with respect to Full Benefit Cancer, Partial Benefit Cancer, Heart Attack, Kidney Failure, Stroke, or any of the Listed Conditions that [the Covered Person]:
 1. experience[s] such Covered Condition; and
 2. [is] Diagnosed with such Covered Condition.
- with respect to Coronary Artery Bypass Graft, that [the Covered Person] undergo[es] a Coronary Artery Bypass Graft.
- with respect to Alzheimer's Disease that [the Covered Person]:
 1. experience[s] such Covered Condition;
 2. [is] Diagnosed with such Covered Condition; and
 3. all other etiologies have been ruled out by a Neurologist; Geriatrician or Neuropsychologist.

[Part-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours per week.]

Partial Benefit Cancer means one of the following conditions that meets the TNM Staging classification and other qualifications specified below:

- carcinoma in situ classified as TisN0M0, provided that Surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a Physician who is Board Certified in the medical specialty that is appropriate for the type of carcinoma in situ involved;
- malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.

Physician means an individual who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and is acting within the scope of a valid license issued in the United States to Diagnose a Covered Condition or to perform the services required for a Covered Condition for which a claim is made. A Physician is not:

- You,
- Your [S]pouse[, Your Domestic Partner] or anyone to whom you are related by blood or marriage;
- anyone with whom you are residing;
- Your adopted or step-child;
- anyone with whom You share a business interest; or
- Your employee.

DEFINITIONS (continued)

Practitioner of the Healing Arts means any person who holds a valid license in the United States to engage in the diagnosis or treatment of disease or any ailment of the human body.

[**Primary Residence** means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.]

Proof means Written evidence satisfactory to us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

Re-Occurs or Re-Occurrence means:

- with respect to Coronary Artery Bypass Graft:
 1. an Occurrence of Coronary Artery Bypass Graft if We have already paid an Initial Benefit for the First Occurrence of Coronary Artery Bypass Graft.
- with respect to Full Benefit Cancer, an Occurrence of Full Benefit Cancer that:
 1. Occurs after an Initial Benefit was paid and [the Covered Person] has not had symptoms of or been treated for the Full Benefit Cancer for a period of [180] days; or
 2. Occurs after an Initial Benefit was paid and is Separate & Unrelated.
- with respect to Partial Benefit Cancer, an Occurrence of Partial Benefit Cancer that:
 1. Occurs after an Initial Benefit was paid and [the Covered Person] has not had symptoms of or been treated for the Partial Benefit Cancer for a period of [180] days; or
 2. Occurs after an Initial Benefit was paid and is Separate & Unrelated.
- with respect to Heart Attack:
 1. an Occurrence of Heart Attack after We have already paid an Initial Benefit for the First Occurrence of Heart Attack.
- with respect to Stroke:
 1. an Occurrence of Stroke after We have already paid an Initial Benefit for the First Occurrence of Stroke.
- [with respect to Listed Conditions:
 1. an Occurrence of rabies if We have already paid an Initial Benefit for any of the Listed Conditions.]

Separate & Unrelated means a Full Benefit Cancer or a Partial Benefit Cancer that is:

- not a metastasis of a previously Diagnosed Full Benefit Cancer; and
- distinct from any previously Diagnosed Full Benefit Cancer or Partial Benefit Cancer.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

DEFINITIONS (continued)

[Spouse means Your lawful spouse. The term does not include any person who:

- is serving in the armed forces, or auxiliary units of the armed forces, of any country;
- lives outside the United States for more than **[6-48]** consecutive months; or
- is insured under the Group Policy as an employee.]

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA), or prolonged reversible ischemic attacks) caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extracranial source.

[Supplemental Benefit(s)] are the following:

- Health Screening Benefit;
- Lodging Benefit;
- Transportation Benefit;
- [Evaluation Benefit;] and
- [NCI Cancer Center Benefit] .]

Surgery means a procedure performed by a Physician involving the cutting of [the Covered Person's] skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic procedures.

TNM Staging means the classification standards for cancer developed by the American Joint Committee on Cancer.

Total Benefit Amount means the maximum aggregate amount, as specified in the Schedule of Insurance, that We will pay for any and all Covered Conditions combined[, per Covered Person, per lifetime,] as provided under this Certificate [or any Certificate it replaces]. [The Total Benefit Amount does not include Supplemental Benefits.]

[Treatment Center means any of the following medical facilities where [a Covered Person] may receive treatment and which is located outside of a 100-mile radius of [the Covered Person's] Primary Residence:

- Hospital;
- radiation therapy center;
- chemotherapy center;
- oncology clinic; or
- specialized free-standing treatment center.]

United States means the United States of America, its territories and its possessions.

We, Us and **Our** mean Metropolitan Life Insurance Company.

Write, Written or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

You and **Your** means [an employee] who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

[ELIGIBLE CLASSES

CLASS 1

All Actively at Work employees of the Group Policyholder who are salaried employees, but not temporary or seasonal employees.

CLASS 2

All Actively at Work employees of the Group Policyholder who are hourly employees, but not temporary or seasonal employees.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on that date. If You enter an eligible class after the date insurance is made available to the members of that class, You will be eligible for insurance on the date You enter the eligible class.

ENROLLMENT PROCESS

If You are eligible for insurance, You may submit an Enrollment Form for insurance. Your insurance will not take effect unless You complete an Enrollment Form and We approve You for insurance. You must also give Written permission to deduct Contributions from Your pay for such insurance.

DATE YOUR INSURANCE TAKES EFFECT

Insurance under this Certificate will take effect for You on the date We approve You for insurance, if on that date You are Actively at Work in an eligible class. If You are not Actively at Work in an eligible class on that date, Your coverage will take effect on the date You return to Active Work in an eligible class.

BENEFIT INCREASES

If you are insured under this Certificate at the time a Benefit Increase is offered for Your eligible class, You will be eligible for the Benefit Increase if you have not already attained the Maximum Benefit Amount. Your Benefit Increase will not take effect unless You complete an Enrollment Form and We approve You for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for such Benefit Increase.

The Benefit Increase will take effect for You on the date We approve You for such Benefit Increase, if on that date You are Actively at Work in a class that is eligible for the Benefit Increase. If You are not Actively at Work in a class that is eligible for the Benefit Increase on that date, Your Benefit Increase will take effect on the date You return to Active Work in a class that is eligible for the Benefit Increase.]

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

[ELIGIBLE CLASSES FOR DEPENDENT INSURANCE

All Class 1 and Class 2 employees of the Group Policyholder as specified in the section titled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

If You are in an eligible class for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect;
- the date an individual becomes Your first Dependent.

If You enter an eligible class for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

ENROLLMENT PROCESS

If You are eligible for Dependent Insurance, You may submit an Enrollment Form for such insurance. Dependent Insurance will not take effect unless You complete an Enrollment Form and, with respect to each Dependent, We approve that Dependent for Dependent Insurance. You must also give Written permission to deduct Contributions from Your pay for Dependent Insurance.

DATE DEPENDENT INSURANCE TAKES EFFECT

Once You are eligible for and have applied for Dependent Insurance, it will take effect on the date We approve each Dependent for Insurance if on that date the Dependent meets the following requirement:

The Dependent is not:

- confined at home under a Physician's care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, insurance for the Dependent will take effect on the date they are no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Once Dependent Insurance is in effect for at least one Dependent Child, any additional child who becomes Your Dependent Child will be insured from the date the child becomes Your Dependent Child. You do not need to enroll such additional Dependent Children for them to become insured for Dependent Insurance.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (CONTINUED)

BENEFIT INCREASES

Dependents who are insured under this Certificate at the time a Benefit Increase that is applicable to Dependents is offered for Your eligible class, will be eligible for the Benefit Increase. Such Benefit Increase will not take effect unless You complete an Enrollment Form with respect to such Dependents and We approve such Dependents for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for the Benefit Increase.

The Benefit Increase will take effect for each Dependent on the date We approve each Dependent for such Benefit Increase, if on that date the Dependent meets the following requirement:

The Dependent is not:

- confined at home under a Physician's care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, the Benefit Increase for the Dependent will take effect on the date such Dependent is no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.]

CRITICAL ILLNESS BENEFITS FOR ALZHEIMER'S DISEASE, CORONARY ARTERY BYPASS GRAFT, FULL BENEFIT CANCER, HEART ATTACK, KIDNEY FAILURE, AND STROKE

If any of the following Covered Conditions First Occurs for [a Covered Person], while [such Covered Person is] insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that We will never pay more [with respect to any Covered Person] than the Total Benefit Amount shown in the Schedule of Insurance.

100% of the Benefit Amount is payable for the following Covered Conditions that First Occurs [for a Covered Person] while [such Covered Person is] insured under this Certificate:

1. Alzheimer's Disease;
2. Coronary Artery Bypass Graft;
3. Full Benefit Cancer;
4. Heart Attack;
5. Kidney Failure; or
6. Stroke.

Payment of this benefit reduces the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

CRITICAL ILLNESS BENEFITS FOR PARTIAL BENEFIT CANCER AND LISTED CONDITIONS

If any of the following Covered Conditions First Occurs for [a Covered Person], while [such Covered Person is] insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that We will never pay more [with respect to any Covered Person] than the Total Benefit Amount shown in the Schedule of Insurance.

25% of the Benefit Amount is payable for the following Covered Conditions that First Occur [for a Covered Person] while [such Covered Person is] insured under this Certificate:

1. Partial Benefit Cancer; or
2. one of the Listed Conditions.

Once We have paid an Initial Benefit for any of the Listed Conditions, We will not pay another Initial Benefit for any of the Listed Conditions.

Payment of this benefit will reduce the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

RE-OCCURRENCE BENEFIT

We will pay the Re-Occurrence Benefit shown in the Schedule of Insurance for a Re-Occurrence subject to the following limitations:

- We will not pay a Re-Occurrence Benefit for a Covered Condition that Re-Occurs during a Benefit Suspension Period; and
- We will not pay a Re-Occurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless:
 - (1) it is Separate & Unrelated; or
 - (2) [the Covered Person] has not, for a period of [180] days, had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit.

Payment of this benefit will reduce the Total Benefit Amount. See the *Reduction on Account of Prior Claims Paid* provision.

REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID

We will reduce what We pay for a claim so that the amount We pay, when combined with amounts for all claims We have previously paid [for the same Covered Person], does not exceed the Total Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition. [This provision does not apply to claim payments for Supplemental Benefits.]

SUPPLEMENTAL BENEFITS

[HEALTH SCREENING BENEFIT

If [a Covered Person] takes one of the screening/prevention measures listed below while [such Covered Person is] insured under this Certificate [and after Your insurance has been in effect for [1-12] months,] We will pay a Health Screening Benefit upon submission of Proof that such measure was taken. When We receive such Proof, We will review it, and if We approve the claim, We will pay a Health Screening Benefit of [\$50-\$200].

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- [annual physical exam;
- biopsies for cancer;
- blood test to determine total cholesterol;
- blood test to determine triglycerides;
- bone marrow testing;
- breast MRI;
- breast ultrasound;
- breast sonogram;
- cancer antigen 15-3 blood test for breast cancer (CA 15-3);
- cancer antigen 125 blood test for ovarian cancer (CA 125);
- carcinoembryonic antigen blood test for colon cancer (CEA);
- carotid doppler;
- chest x-rays;
- clinical testicular exam;
- colonoscopy;
- digital rectal exam (DRE);
- Doppler screening for cancer;
- Doppler screening for peripheral vascular disease;
- echocardiogram;
- electrocardiogram (EKG);
- endoscopy;
- fasting blood glucose test;
- fasting plasma glucose test;
- flexible sigmoidoscopy;
- hemoccult stool specimen;
- hemoglobin A1C;
- human papillomavirus (HPV) vaccination;
- lipid panel;
- mammogram;
- oral cancer screening;
- pap smears or thin prep pap test;
- prostate-specific antigen (PSA) test;
- serum cholesterol test to determine LDL and HDL levels;
- serum protein electrophoresis;
- skin cancer biopsy;
- skin cancer screening;
- skin exam;
- stress test on bicycle or treadmill;
- tests for sexually transmitted infections (STIs);

SUPPLEMENTAL BENEFITS (continued)

HEALTH SCREENING BENEFIT (continued)

- thermography;
- two hour post-load plasma glucose test;
- ultrasounds for cancer detection;
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms; or
- virtual colonoscopy.]

We will only pay one Health Screening Benefit [per Covered Person] per calendar year.

Payment of this benefit will not reduce the Total Benefit Amount.]

[LODGING BENEFIT

If [the Covered Person] is Diagnosed with a Covered Condition and if the conditions of this provision are met, [the Covered Person] will be eligible for the Lodging Benefit. If [the Covered Person] receives treatment for the Covered Condition at a Treatment Center, while [such Covered Person] is insured under this Certificate [and after Your insurance has been in effect for [1-12] months], We will pay the following benefit, subject to the limitations below:

- We pay \$[60-100] per day, up to a maximum of [60-180] days per calendar year, when [a Covered Person] stays in a Lodging while receiving treatment.

Limitations:

- We will only pay a Lodging Benefit for the 24 hours prior to [the Covered Person's] receipt of treatment, and for the 24 hours following the receipt of treatment.
- You must submit Proof that the treatment was received.
- You must submit Proof that [the Covered Person] incurred an expense for staying at a Lodging.

Payment of this benefit will not reduce the Total Benefit Amount.]

[TRANSPORTATION BENEFIT

If [the Covered Person] is Diagnosed with a Covered Condition and if the conditions of this provision are met, [the Covered Person] will be eligible for the Transportation Benefit. If [the Covered Person] receives treatment at a Treatment Center for the Covered Condition, while [such Covered Person] is insured under this Certificate [and after Your insurance has been in effect for [1-12] months], We will pay the following benefit, subject to the limitations below:

- We will pay \$[0.25-1.00] per mile for a maximum of \$[1,000-2,500] per round trip, up to a maximum of \$5,000 per calendar year, for [the Covered Person] receiving benefits for the related Covered Condition. Mileage is measured from [the Covered Person's] Primary Residence to the Treatment Center.

Limitations:

- We will not pay more than \$5,000 in any calendar year for the Transportation Benefit.
- You must submit Proof that the treatment was received.

Payment of this benefit will not reduce the Total Benefit Amount.]

EVALUATION BENEFIT

For purposes of this section:

Evaluation Center means a facility that is:

- licensed or certified under the laws where it is located to provide diagnostic services for the Covered Condition for which evaluation is sought[; and
- which has been recognized by the Group Policyholder in Writing as an evaluation center for purposes of the Evaluation Benefit].

If [a Covered Person is] Diagnosed with a Covered Condition other than Listed Conditions, and if the conditions of this provision are met, [that Covered Person] will be eligible for the Evaluation Benefit. If [a Covered Person] receives an evaluation at an Evaluation Center while [such Covered Person is] insured under this Certificate [and after Your insurance has been in effect for [1-12] months,] We will pay the following benefit, subject to the limitations below:

- **[\$500-1,000]** for the evaluation or consultation; and
- **[\$250-500]** if the Evaluation Center is more than 100 miles from [the Covered Person's] Primary Residence.

Limitations:

- This benefit is limited to one payment for each Initial Benefit or Re-Occurrence Benefit received by [the Covered Person] for any Covered Condition other than Listed Conditions and only if an evaluation is received by [the Covered Person].
- We will only pay this benefit if We have already paid an Initial Benefit or Re-Occurrence Benefit for the Covered Condition for which [the Covered Person is] receiving an evaluation.
- You must submit Proof that the evaluation was received.
- We will not pay for benefits under this section for more than [5] evaluations [per Covered Person] while coverage is in effect under this Certificate.

Payment of this benefit will not reduce the Total Benefit Amount.

NCI CANCER CENTER BENEFIT

For purposes of this section:

NCI Cancer Center means any facility designated by the National Cancer Institute as an “NCI Designated Cancer Center.”

If [a Covered Person is] Diagnosed with either Full Benefit Cancer or Partial Benefit Cancer and if the conditions of this provision are met, [that Covered Person] will be eligible for the NCI Cancer Center Benefit. If [a Covered Person] receives an evaluation at an NCI Cancer Center while [such Covered Person is] insured under this Certificate [and after Your insurance has been in effect for [1-12] months,] We will pay the following benefit, subject to the limitations below:

- \$[500-1,000] for the evaluation or consultation; and
- \$[250-500] if the NCI Cancer Center is more than 100 miles from [the Covered Person's] Primary Residence.

Limitations:

- This benefit is limited to one payment for each Initial Benefit or Re-Occurrence Benefit received by [the Covered Person] for Full Benefit Cancer and Partial Benefit Cancer and only if an NCI Cancer Center evaluation is received by [the Covered Person].
- We will only pay this benefit if We have already paid an Initial Benefit or Re-Occurrence Benefit for the Full Benefit Cancer or the Partial Benefit Cancer for which [the Covered Person is] receiving an evaluation.
- You must submit Proof that the evaluation was received.

Payment of this benefit will not reduce the Total Benefit Amount.]

WAIVER OF PREMIUMS

If You become Disabled while you are under age 70 and insured under this Certificate, and You remain Disabled continuously for [90-365] days, Proof of your Disability must be sent to us in order to submit a claim for Waiver of Premium. Such Proof must be sent to us during the [90-365] day period that follows the [ninetieth – three hundred sixty-fifth] day of Your continuous Disability or You will not be eligible for Waiver of Premiums. As part of such Proof, We may choose a Physician to examine You to verify that You are Disabled. If We do so, We will pay for such exam.

When we receive such Proof, we will review the claim and if we approve it, we will waive the premiums due for You and Your Dependents starting with the first premium that becomes due on or after the date You have been Disabled continuously for [90-365] days, subject to the following:

- We will not waive premiums for any period during which You are not under the care of a Physician for the Covered Condition that causes Your Disability;
- We will not waive premiums if you do not remain insured during the first [90-365] days of continuous Disability either under this Certificate [or under a certificate issued to You pursuant to the PORTABILITY OF COVERAGE section]; and
- We will not waive premiums if Your Disability is not solely caused by a Covered Condition for which We have paid a benefit under this Certificate.

If We waive any premium under this provision that has already been paid to Us, We will return the premium to whomever paid it to Us.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically ask You to send Us Proof that You continue to be Disabled.

We will continue to waive premiums under this provision until the earliest of:

- the date You are no longer Disabled;
- Your seventieth birthday;
- the date You fail to send us Proof that You continue to be Disabled as required under this provision; or
- the date the Group Policy ends.

IMPORTANT NOTICE

[On the date Your insurance ends, We will not know whether You will be able to satisfy the Disability and Proof requirements specified above. For this reason, We urge You to consider taking the following steps:

Step 1 When Your Insurance ends, ask the Group Policyholder if such insurance will be continued with premium payment by the Group Policyholder. If the answer is yes, ask if such continuation will be for at least [90-365] days. If the answer is yes, file a claim for Waiver of Premiums under this section at the end of [90-365] days of continuous Disability.

If the Group Policyholder will not continue insurance as described in Step 1, proceed to Step 2.

WAIVER OF PREMIUMS (continued)

Step 2. Read the section[s] titled [PORTABILITY OF COVERAGE and] CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT. You may have the option to continue your insurance under the Group Policy [or under another policy issued by us for people exercising their portability option].

If the Group Policyholder does not continue Your insurance as described in Step 1 and You do not continue your insurance as described in Step 2 You will not be eligible for Waiver of Premiums because You will not have been continuously insured during the first [90-365] days of Disability.]

EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS

Alzheimer's Disease

We will not pay benefits for a Diagnosis of Alzheimer's Disease for:

- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);
- substance-induced conditions; or
- any form of dementia that is not diagnosed as Alzheimer's Disease.

Coronary Artery Bypass Graft

We will not pay benefits for Coronary Artery Bypass Graft:

- performed outside the United States; or
- that does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).

Full Benefit Cancer

We will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- a previously Diagnosed Full Benefit Cancer for which We did not pay an Initial Benefit that has metastasized;
- any recurrence of a previously Diagnosed Full Benefit Cancer for which We did not pay an Initial Benefit;
- any condition that is Partial Benefit Cancer;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1N0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis;
- any tumor in the presence of human immuno-deficiency virus;
- any non-melanoma skin cancer unless there is metastasis; or
- any malignant tumor classified as less than T1N0M0 under TNM Staging.

Partial Benefit Cancer

We will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- any recurrence of a previously Diagnosed Partial Benefit Cancer for which We did not pay an Initial Benefit;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter;
- any tumor in the presence of human immuno-deficiency virus;
- any non-melanoma skin cancer; or
- any melanoma in situ classified as TisN0M0 under TNM Staging.

EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS (continued)

Stroke

We will not pay benefits for a Diagnosis of Stroke for:

- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

Listed Conditions

We will not pay benefits for:

- a Diagnosis of multiple sclerosis for clinically isolated syndrome (CIS);
- a Diagnosis of systemic lupus erythematosus (SLE) for any form of Lupus that is not Diagnosed as systemic lupus erythematosus (SLE); or
- a suspected or probable Diagnosis of a Listed Condition.

ADDITIONAL PROOF REQUIREMENTS FOR EACH COVERED CONDITION

Alzheimer's Disease

Proof of Alzheimer's Disease requires a Diagnosis made in Writing by a Neurologist, Geriatrician, or Neuropsychologist and supported by all of the following:

- formal neuropsychological testing performed by a Neuropsychologist confirming dementia;
- laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and
- magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

The Covered Condition for Alzheimer's Disease will be deemed to Occur on the date that the Diagnosis of Alzheimer's Disease is made and all other etiologies have been ruled out.

Coronary Artery Bypass Graft

Proof of Coronary Artery Bypass Graft requires submission of medical records evidencing that the Coronary Artery Bypass Graft:

- was determined to be medically necessary by a Physician who is Board Certified in cardiology;
- was supported by pre-operative angiographic evidence; and
- has been performed.

The Covered Condition for Coronary Artery Bypass Graft will be deemed to Occur on the date that the Coronary Artery Bypass Graft is performed.

Full Benefit Cancer

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Full Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician who is Board Certified in pathology. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

Partial Benefit Cancer

Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Partial Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician who is Board Certified in pathology. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

ADDITIONAL PROOF REQUIREMENTS FOR EACH COVERED CONDITION (continued)

Heart Attack

Diagnosis of Heart Attack must be made in Writing by a Physician and supported by medical records showing an elevation of enzymes, troponins or other biochemical cardiac markers, and two of the three following criteria associated with the Heart Attack for which a claim is being made:

1. typical chest pain characteristic of an acute myocardial infarction, requiring [the Covered Person] to be Hospitalized as an inpatient;
2. electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time [the Covered Person] experiences the Heart Attack for which a claim is being made, which changes are indicative of an acute myocardial infarction, but, if [the Covered Person] had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Heart Attack must show changes from the [the Covered Person's] last electrocardiogram, and such changes must be indicative of an acute myocardial infarction; or
3. confirmatory imaging studies such as thallium scans, or echocardiograms indicative of an acute myocardial infarction, but, if the [Covered Person] had any prior imaging studies, the imaging studies presented as Proof of Heart Attack must show changes from [the Covered Person's] last imaging studies, which changes must be indicative of a myocardial infarction.

The Covered Condition for Heart Attack will be deemed to Occur on the date the Diagnosis of Heart Attack is made.

Kidney Failure

Diagnosis of Kidney Failure must be made in Writing by a Physician who is Board Certified in nephrology, and must be supported by medical records. The Covered Condition for Kidney Failure will be deemed to Occur on the date the Diagnosis of Kidney Failure is made.

Stroke

Diagnosis of Stroke must be made in Writing and be based upon medical records indicating objective evidence of significant neurological impairment that is functional, measurable and permanent as demonstrated by magnetic resonance imaging, computerized tomography or other reliable imaging techniques. Such neurological impairment must be confirmed in Writing no earlier than 30 days after the cerebrovascular accident or incident by a Physician who is Board Certified in neurology and be based upon objective evidence of significant neurological, motor or sensory impairment, which impairment must be present on the date that such Written confirmation is made. The Covered Condition for Stroke will be deemed to Occur on the date the Diagnosis of Stroke is made.

Listed Conditions

Diagnosis of a Listed Condition must be made in Writing by a Physician and must be supported by medical records. The Covered Condition for a Listed Condition will be deemed to Occur on the date the Diagnosis of a Listed Condition is made.

LIMITATIONS

BENEFIT REDUCTION DUE TO AGE

Your Benefit Amount and the Total Benefit Amount will each be reduced when You reach certain ages, as shown in the Schedule of Insurance. [The Benefit Amount and the Total Benefit Amount for Your Spouse or Domestic Partner will each be reduced when Your Spouse or Domestic Partner reach certain ages, as shown in the Schedule of Insurance.]

[If the Total Benefit Amount, when reduced under the *Benefit Reduction Due to Age* provision, is less than or equal to the sum of all benefits previously paid under this Certificate, insurance under this Certificate will end on the date of such reduction.]

[LIMITATIONS (continued)]

WAITING PERIOD

On the date a Covered Person's insurance under this Certificate becomes effective, a waiting period starts with respect to such insurance. Such insurance will be void if [the Covered Person]:

- experience[s] a Covered Condition during the waiting period; or
- exhibits symptoms, or any medical or physical conditions, during the waiting period that would cause an ordinarily prudent person to seek diagnosis, care or treatment, and [the Covered Person is] Diagnosed with Partial Benefit Cancer or Full Benefit Cancer.

On the date a Benefit Increase becomes effective, a waiting period starts with respect to the Benefit Increase. Such Benefit Increase will be void [with respect to a Covered Person] if [the Covered Person]:

- experience[s] a Covered Condition during the waiting period; or
- exhibits symptoms, or any medical or physical conditions, during the waiting period that would cause an ordinarily prudent person to seek diagnosis, care or treatment, and [the Covered Person is] Diagnosed with Partial Benefit Cancer or Full Benefit Cancer.

Contributions You have paid for any insurance that is voided under this provision will be returned to You without interest[, except if Your Dependent Child is the Covered Person whose insurance is void under this provision. If insurance for a Dependent Child is void under this provision, Contributions paid for that insurance will be returned to You only if there is no insurance remaining in effect for any Dependent Child under this Certificate. If You are the Covered Person whose insurance is void under this provision, and as a result You no longer have any insurance in effect under the Group Policy, insurance for Your Dependents will also be void.]

If a claim is denied under this *Waiting Period* provision, at Your option, We will exclude the Covered Condition and insurance that would otherwise be void under this *Waiting Period* provision will not be void. In order for You to exercise this option, You must notify Us in Writing within 30 days after We notify You that Your claim is denied under this *Waiting Period* provision.

The length of the waiting period is shown in the Schedule of Insurance.

PREEXISTING CONDITION EXCLUSION

Preexisting Condition means a sickness or injury for which, in the [3-12] months before [a Covered Person] become[s] insured under this Certificate, or before any Benefit Increase with respect to such Covered Person:

- medical advice, treatment or care was sought by [such Covered Person], or, recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts; or
- symptoms, or any medical or physical conditions existed that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

We will not pay benefits for Covered Conditions that are caused by or result from a Preexisting Condition if the Covered Condition Occurs during the first [3-12] months that [a Covered Person is] insured under this Certificate.

With respect to a Benefit Increase, We will not pay benefits for such Benefit Increase for Covered Conditions that are caused by or result from a Preexisting Condition if such Covered Condition Occurs during the first [3-12] months after such increase in the Total Benefit Amount.

This provision does not apply to benefits for the following Covered Conditions: Heart Attack and Stroke.

OTHER EXCLUSIONS

EXCLUSION FOR INTOXICATION

We will not pay benefits for any Covered Condition that is caused by, contributed to by, or results from [a Covered Person's] involvement in an incident, where [such Covered Person is] intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

Intoxicated means that [the Covered Person's] alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

GENERAL EXCLUSIONS

We will not pay benefits for any Covered Conditions caused by, contributed to by, or resulting from [a Covered Person]:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane;
- voluntarily taking or using any drug, medication or sedative unless it is:
 - taken or used as prescribed by a Physician, or
 - an "over the counter" drug, medication or sedative taken according to package directions;
- engaging in any illegal occupation; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

We will not pay benefits for Covered Conditions arising from war or any act of war, even if war is not declared.

We will not pay benefits for any Covered Condition for which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States.

We will not pay benefits for any Covered Condition that does not First Occur [for a Covered Person] while [such Covered Person is] insured under this Certificate.

WHEN INSURANCE ENDS

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

- [the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- [the date the Total Benefit Amount has been paid for You;]
- the end of the period for which the last full premium has been paid for You;
- the date You cease to be in an eligible class; or
- the date Your employment ends [for any reason other than Your retirement]].

[DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance will end on the earliest of:

- [the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the date the person ceases to be a Dependent;
- [the date the Total Benefit Amount has been paid for that Dependent;]
- the date You cease to be in a class that is eligible for Dependent Insurance;
- [the date You retire in accordance with the Group Policyholder's retirement plan;] or
- the end of the period for which the last full premium has been paid for the Dependent.]]

[Please refer to the provision entitled *Waiver of Premiums* for information concerning continuation of Your insurance if Your insurance ends while You are Disabled.]

[In certain cases insurance may be continued as stated in the sections titled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT or PORTABILITY OF COVERAGE. Please see that section for details.]

SPECIAL RULES FOR COVERED PERSONS PREVIOUSLY INSURED UNDER ANOTHER GROUP CRITICAL ILLNESS INSURANCE POLICY ISSUED TO THE GROUP POLICYHOLDER

The Group Policy is replacing another policy of group critical illness insurance that was issued to the Group Policyholder. This section explains how the replacement of that other group critical illness insurance policy will affect people who were covered under that policy.

In this section, the terms listed below will have the meanings listed below.

New Policy means the Group Policy under which this Certificate is issued.

Old Policy means the policy of group critical illness insurance that was replaced by the New Policy.

[Each Covered Person who was insured under the Old Policy on the date that it ended] will be:

- insured under the New Policy on the date it takes effect; and
- credited for the time [such Covered Person] had been continuously insured under the Old Policy on the date it ended in determining:
 1. [whether a Covered Condition is a Preexisting Condition under the Preexisting Condition Exclusion in this Certificate;] [and
 2. whether a Covered Condition is subject to the Waiting Period in this Certificate.]

To the extent that benefits were paid under the Old Policy with respect to [a Covered Person] for any Covered Condition:

- if that Covered Condition Occurs under the New Policy, it will be treated as a Re-Occurrence; and
- the Total Benefit Amount with respect to [such Covered Person] under this Certificate will be reduced.

[The form that was used to enroll [a Covered Person] for insurance under the Old Policy will be used as the Enrollment Form for [such Covered Person] under the New Policy.]

PORTABILITY OF COVERAGE

Insurance provided to You [and Your Dependents] under this Certificate is portable in certain situations, as described in this section, if you reside in a jurisdiction where portability of coverage is available. Evidence of insurability will not be required to exercise this portability option. If You continue your insurance under this section, You may also continue Dependent Insurance.

You may request in Writing during the Request Period specified below to continue insurance for You and Dependent Insurance, under another group policy issued by Us for exercising this portability option if You have been insured under this Certificate for at least 90 days, and Your insurance ends because:

- [Your employment ends; or
- You cease to be in a class that is eligible for such insurance.]

If You make a request under this portability option, We will issue a new certificate of insurance which will explain the new insurance benefits. The amount of insurance [for each person continuing insurance under the new certificate] will be the same as the Total Benefit Amount that is in force [with respect to the person under this Certificate] on the day insurance under this Certificate ends, less any benefits that are paid [with respect to that person] under this Certificate. However, the insurance benefits under the new certificate may not be the same as those under this Certificate that ended under the Group Policy.

A request under this portability option may be made, if on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Group Policyholder of its intent to end the Group Policy; and
- You reside in a jurisdiction that permits portability.

REQUEST PERIOD

To continue insurance under this portability option, We must receive a completed Written request on a form approved by Us within the Request Period which begins on the date Your coverage ends, and ends 31 days later.

You have 31 days from the date coverage terminated to request continuation of insurance under a different group policy. If You do not request to continue insurance within the Request Period, You cannot exercise this portability option.

PREMIUMS FOR THE NEW CERTIFICATE

When You make a request to continue insurance under this portability option, You must pay the first premium during the Request Period. All premium payments must be made directly to Us. When We issue the new certificate, We will also provide a schedule of premiums and payment instructions.

[IF YOU ARE DISABLED ON THE DATE YOUR EMPLOYMENT ENDS

If You are Disabled on the date Your employment ends and You elect to continue your insurance under this PORTABILITY OF COVERAGE section You may at a later date become approved to have Your premiums waived under the *Waiver of Premiums* provision of this Certificate. If You are so approved, all insurance continued under this PORTABILITY OF COVERAGE section will end and We will return any premiums paid by You for such insurance.]

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

[FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law, if such Dependent Child developed such physical or mental handicap prior to the attainment of age 19 and is chiefly dependent upon You for support and maintenance. Notice of such handicap must be sent to Us. At your expense, We may request Proof of such handicap at reasonable intervals while such handicap continues.

Except as stated in the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Dependent Child, except for the age limit.]

FOR FAMILY AND MEDICAL LEAVE

[Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.]

[AT THE GROUP POLICYHOLDER'S OPTION

The Group Policyholder has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. This election applies to Class 1 employees as defined in the section titled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU. If Your insurance is continued, You may also continue Dependent Insurance.

Insurance will continue for the following periods:

- for the period You cease Active Work in an eligible class due to injury or sickness, up to [1 – 60] months;
- for the period You cease Active Work in an eligible class due to part-time work, layoff or strike, up to [1 – 60] months;
- for the period You cease Active Work in an eligible class due to any other Group Policyholder approved leave of absence, up to [1 –60] months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at that time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at that time, Your employment will be considered to end and Your insurance will end in accordance with the *Date Your Insurance Ends* provision of the section titled WHEN INSURANCE ENDS.

If Your insurance ends, Your Dependent Insurance will also end in accordance with the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS.]

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (CONTINUED)

[IF YOU ARE DISABLED ON THE DATE YOUR EMPLOYMENT ENDS

If You are Disabled on the date Your employment ends and You elect to continue your insurance under this CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section, You may at a later date become approved to have Your premiums waived under the *Waiver of Premiums* provision of this Certificate. If You are so approved, all insurance continued under this CONTINUATION OF INSURANCE section will end and We will return any premiums paid to whomever paid them for such insurance.]

[AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

Insurance provided under this Certificate may be continued with premium payment in certain situations, as described in this provision. This is referred to in this provision as “Continued Insurance”. Evidence of insurability will not be required to obtain Continued Insurance. [If You obtain Continued Insurance under this provision, You may also continue Dependent Insurance.] For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as “Group Billed Insurance”.

You may obtain Continued Insurance for You [and for Your Dependents] by making a request in Writing during the Request Period specified below if Your Group Billed Insurance ends because:

- Your employment ends; or
- You cease to be in a class that is eligible for Group Billed Insurance.

However, You cannot obtain Continued Insurance if Group Billed Insurance:

- ends for all employees;
- ends for the class of employees that You are in;
- ends for the class of employees that You were last in before Your Group Billed Insurance ends;
- ends because You failed to pay a required Contribution; or
- ends on a date preceding which You have not been continuously insured for at least 90 days under the Group Policy.

REQUEST PERIOD

To obtain Continued Insurance, We must receive Your completed Written request on a form approved by Us within the Request Period which begins on the date Your Group Billed Insurance ends, and ends 31 days later. If You do not request Continued Insurance within the Request Period, You cannot obtain Continued Insurance.

PREMIUMS FOR CONTINUED INSURANCE

The premium that You must pay for Continued Insurance may include the amount, if any, that You contributed for Your Group Billed Insurance before it ended, plus any amount the Employer paid. Premium rates for Continued Insurance will be the same as premium rates charged for Group Billed Insurance. Premiums rate increases or decreases that apply to Group Billed Insurance will apply to Continued Insurance as well. When You make a request to obtain Continued Insurance, You must pay the first premium during the Request Period. All premium payments must be made directly to Us. When We approve Your request for Continued Insurance, We will also provide a schedule of premiums and payment instructions.

END OF CONTINUED INSURANCE

Continued Insurance will end on the earliest of the following dates:

- the date Group Billed insurance ends for all employees;
- the date Group Billed insurance ends for the class of employees that You are in;
- the date Group Billed insurance ends for the class of employees You were last in before obtaining Continued Insurance;
- the date You die;
- [the date the Total Benefit Amount has been paid for You;][or]
- if You do not pay a premium that is required for Continued Insurance, the last day of the period for which a required premium payment was made[;
- with respect to Dependent Insurance, the date Continued Insurance for You ends for any reason;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for all employees;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for the class of employees that You are in
- with respect to Dependent Insurance, the date Dependent Insurance ends for the class of employees that You were last in before obtaining Continued Insurance;
- with respect to Dependent Insurance, the date the Dependent no longer meets the definition of a Dependent; [or]
- with respect to a Dependent's insurance, the date the Total Benefit Amount has been paid for that Dependent].

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at that time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at that time, Your employment will be considered to end and Your insurance will end in accordance with the *Date Your Insurance Ends* provision of the section titled WHEN INSURANCE ENDS.

[If Your insurance ends, Your Dependent Insurance will also end in accordance with the *Date Dependent Insurance Ends* provision of the section titled WHEN INSURANCE ENDS.]

[IF YOU ARE DISABLED ON THE DATE YOUR EMPLOYMENT ENDS

If You are Disabled on the date Your employment ends and You elect to continue your insurance under this CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section, You may at a later date become approved to have Your premiums waived under the *Waiver of Premiums* provision of this Certificate. If You are so approved, all insurance continued under this CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section will end and We will return any premiums paid to whomever paid them for such insurance.]

CLAIMS

FILING A CLAIM

To file a claim for benefits under this Certificate, You must give Us notice of the claim and submit Proof of the claim to Us as described in this provision.

Notice of claim and Proof must be given to Us by following the steps set forth below:

Step 1

You must give Us notice by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

Step 2

We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

Step 3

When You receive the claim form You should fill it out as instructed and return it with the required Proof described in this Certificate and the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, You may send Us Proof using any form sufficient to provide Us with the required Proof.

Step 4

You must give Us Proof not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

PAYMENT OF BENEFITS

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy.

All benefits paid under this Certificate while You are living will be paid to You[, unless You have assigned this insurance]. But, if You are not legally competent to claim or receive benefits under this Certificate, we may pay up to [\$10,000] to anyone related to You by blood or marriage who We believe is entitled to it. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If You designated a beneficiary, upon Your death we will pay to Your beneficiary any amount that is or becomes due. You may designate a beneficiary [in Your Enrollment Form]. You may change Your beneficiary at any time. To do so, You must send a Signed and dated, Written request to [the Group Policyholder] using a form satisfactory to Us. Your Written request to change the beneficiary must be sent to [the Group Policyholder] no later than [30-90] days of the date You Sign such request.

[Unless otherwise requested, We may at Our option pay benefits in one sum or by placing the amount in an account that earns interest. The person to whom we pay the benefits will have immediate access to all or any part of the account. We will pay interest on the benefits from the date they become payable until all funds in the account have been withdrawn.]

CLAIMS (continued)

Payment Of Benefits (continued)

You do not need the beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more beneficiaries are designated and their shares are not specified, they will share the insurance equally.

[If there is no beneficiary designated or no surviving beneficiary at Your death, We may determine the beneficiary to be one or more of the following who survive You, in the order listed below:

1. Your [Spouse or Domestic Partner];
2. Your child(ren);
3. Your parents(s); or
4. Your sibling(s).

Instead of making payment in the order above, We may pay Your estate.] Any payment made in good faith will discharge Our liability to the extent of such payment.

AUTHORIZATIONS

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

EXAMINATIONS

At Our expense, as often as is reasonably necessary, We may require You to have an independent examination by a Physician of Our choice.

At Our expense, as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

AUTOPSY

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

TIME LIMIT ON LEGAL ACTIONS

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

GENERAL PROVISIONS

CHANGES IN STANDARDS

This Certificate refers to classification standards for disease that have been developed by independent third parties. If those independent third parties change the classification standards, or if new standards are developed that become generally accepted in the medical community in the United States, We will interpret this Certificate in a manner that recognizes such changed or new standards when We determine it is appropriate to do so.

ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- [Your Enrollment Form;]
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

[INCONTESTABILITY: STATEMENTS MADE BY YOU

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in an Enrollment Form that is in Writing;
- You have Signed the Enrollment Form; and
- a copy of the Enrollment Form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a Benefit Increase after the Benefit Increase has been in force for 2 years, unless such statement is fraudulent.]

MISSTATEMENTS

If Your [or Your Dependent's] age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or contributions.

[If Your [or Your Dependent's] tobacco usage is misstated, the information regarding the correct tobacco usage will be used, as appropriate, to adjust the benefits and/or contributions.]

ASSIGNMENT

The Benefits under the Group Policy are [not assignable except as required by law].

CONFORMITY WITH LAW

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

GROUP CRITICAL ILLNESS ENROLLMENT FORM
[FOR XYZ CORPORATION -- Group Report No.]

Section To Be Completed By Employee						
Name (print)	First	Middle	Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
	[John]	A.	Doe]	[111-22-3333]	[12-15-69]	
Address Street	City		State	Zip Code	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced
[100 Any Street]	[Any Town]		[YJ]	[12345]		
E-mail Address				Phone No. (include area code)		
[jdoe@gmil.com]				[111-222-3333]		
Employee ID No			State/Country of Birth			
[1555333]			[Texas, US]			

If requesting coverage for Dependent coverage (Spouse and Child), complete section below:

Name (Last, First, MI)	Date of Birth	Sex (M/F)	If dependent children are full-time students in college, vocational or trade school, please list name of school
Spouse: [Doe, Jane, A]	[1-5-70]	[F]	
Child(ren): [Doe, Johnnie, A.]	[7-4-01]	[M]	
[Doe, Janie, A.]	[1-1-03]	[F]	
_____	_____	_____	_____
_____	_____	_____	_____

COVERAGE REQUEST DATA:

I have received and read a copy of the outline of coverage for the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below. I understand that no person will be covered until they are accepted for coverage by MetLife. I also understand that my Spouse/Domestic Partner and Dependent Child(ren) are not eligible for coverage if I am not approved for coverage.

I request the following coverage:

Employee Coverage: Benefit Amount	Dependent Spouse Coverage: Benefit Amount (cannot exceed employee benefit amount)	Dependent Child Coverage: Benefit Amount (cannot exceed employee benefit amount)
<input type="checkbox"/> \$10,000 <input checked="" type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	<input type="checkbox"/> \$10,000 <input checked="" type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000	<input checked="" type="checkbox"/> \$5,000

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

Have you smoked cigarettes, or used any other tobacco or nicotine product within the [12 - 24] months preceding the date of this enrollment form? **Employee** Yes No **Spouse** Yes No

[Medical Information

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

- | | Employee | Spouse |
|---|---|---|
| [1.] Do you currently have [diabetes,] Alzheimer's disease, mild cognitive impairment, pre-dementia or other form of dementia, or in the last [2 months – 10 years] have you had any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; or (vi) an organ transplant (or been on the list for an organ transplant)? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

[IF YOU ARE APPLYING FOR [A BENEFIT AMOUNT FOR YOU OF GREATER THAN \$10,000], PLEASE ANSWER THE REST OF THE MEDICAL QUESTIONS. OTHERWISE, PLEASE PROCEED TO THE BENEFICIARY DESIGNATION SECTION.]

[1.] Your: Height [5] feet [11] inches Weight [208] lbs.

[2.] Your Spouse's: Height [5] feet [6] inches Weight [130] lbs.

- | | Employee | Spouse |
|--|---|---|
| [3.] Have you been hospitalized* during the 24 months preceding the date of this enrollment form for any reason other than pregnancy?
[* "Hospitalized" means admission for inpatient care in a hospital; receipt of care in a hospice facility, an intermediate care facility or a long term care facility; or receipt of the following treatment wherever performed: chemotherapy; radiation therapy; or dialysis.] | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| [4.] Are you now taking any prescribed medications? If "yes," list all medications and dosages:

_____ | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| [5.] On the date of this application are you receiving or applying for any disability benefits or confined at home under the care of a physician due to a sickness or injury? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| [6.] Have you EVER had an organ transplant, been told by a physician or other health care provider that you require an organ transplant or are you now on a list for organ transplant? | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| [7.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for: | | |

a. heart attack or coronary artery disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
b. cancer (except basal cell carcinoma), tumors, Hodgkin's disease, leukemia or other blood disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
c. stroke or transient ischemic attack ("TIA")?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
d. Alzheimer's disease, mild cognitive impairment, Lewy body disease, Pick's disease or other form of dementia or pre-dementia?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
e. cerebral palsy, muscular dystrophy, poliomyelitis, Huntington's disease (Huntington's chorea), multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease) or other neurological disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
f. blood clots, sickle cell anemia or other circulatory disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
g. high cholesterol or high blood pressure?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
h. diabetes, impaired glucose tolerance, or high blood sugar?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
i. prostate trouble or an elevated prostate specific antigen ("PSA") test result?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
j. chronic hepatitis B (including if a carrier), hepatitis C, cirrhosis or other liver disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
k. kidney disease or disorder other than kidney stones?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
l. myasthenia gravis, Addison's disease (adrenal hypofunction), thyroid disease or other gland disorder?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
m. systemic lupus erythematosus (SLE), systemic sclerosis (scleroderma) or other autoimmune disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
n. emphysema, pulmonary fibrosis, cystic fibrosis, tuberculosis or other lung disorder (not including asthma, pneumonia or cold)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
o. familial adenomatous polyposis (Gardener's syndrome) [or tumors]?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Medical Information (continued)

Employee

Spouse

- [8.] In the last [2 months – 10 years], have you had symptoms of: (i) cancer; (ii) kidney disease; (iii) coronary artery disease; (iv) stroke; (v) Alzheimer's disease; (vi) mild cognitive impairment; or (vii) other form of dementia or pre-dementia, for which a member of the medical profession advised you to have medical tests which have not been completed or for which you have not received results? Yes No Yes No
- [9.] Have you ever had symptoms of [diabetes,] Alzheimer's disease, mild cognitive impairment, pre-dementia or other form of dementia, or have you ever had any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; or (vi) an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [10.] Do you currently have [diabetes,] Alzheimer's disease, mild cognitive impairment, pre-dementia or other form of dementia or have you ever had any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; or (vi) an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [11.] Have two or more of your biological parents, brothers or sisters (either living or dead, but prior to [50 - 75]) been diagnosed with the same condition from the following list of conditions: (i) Alzheimer's disease; (ii) diabetes; (iii) heart disease; (iv) stroke; (v) kidney disease; or (vi) cancer (except basal cell carcinoma)? Yes No Yes No
- [12.] Have you EVER been diagnosed or treated by a member of the medical profession for Human Immuno-deficiency Virus ("HIV"), Acquired Immune Deficiency Syndrome ("AIDS") or AIDS Related Complex ("ARC")? Yes No Yes No
- [13.] In the 12 months preceding the date of the enrollment form, have you experienced unexplained weight loss of 10 pounds or more[, dizziness or shortness of breath]? Yes No Yes No
- [14.] In the last [2 months – 10 years] have you had any of the following: (i) a heart attack; (ii) coronary artery disease; or (iii) a stroke? Yes No Yes No
- [15.] Do you currently have diabetes; impaired glucose tolerance; or high blood sugar? Yes No Yes No
- [16.] In the last [2 months – 10 years] have you been diagnosed, treated, or given medical advice by a physician or other health care provider for: diabetes; impaired glucose tolerance; or high blood sugar? Yes No Yes No
- [17.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for: diabetes; impaired glucose tolerance; or high blood sugar? Yes No Yes No
- [18.] Have you EVER had any of the following: (i) Addison's disease (adrenal hypofunction) ; (ii) amyotrophic lateral sclerosis (Lou Gehrig's disease); (iii) cerebrospinal meningitis (bacterial); (iv) cerebral palsy; (v) cystic fibrosis; (vi) diphtheria; (vii) encephalitis; (viii) Huntington's disease (Huntington's chorea); (ix) Legionnaire's disease; (x) malaria; (xi) multiple sclerosis; (xii) muscular dystrophy; (xiii) myasthenia gravis; (xiv) necrotizing fasciitis; (xv) osteomyelitis; (xvi) poliomyelitis; (xvii) rabies; (xviii) sickle cell anemia; (xix) systemic lupus erythematosus (SLE); (xx) systemic sclerosis (scleroderma); (xxi) tetanus; or (xxii) tuberculosis? Yes No Yes No
- [19.] In the last [2 months – 10 years] have you been diagnosed, treated, or given medical advice by a physician or other health care provide for: (i) Addison's disease (adrenal hypofunction) ; (ii) amyotrophic lateral sclerosis (Lou Gehrig's disease); (iii) cerebrospinal meningitis (bacterial); (iv) cerebral palsy; (v) cystic fibrosis; (vi) diphtheria; (vii) encephalitis; (viii) Huntington's disease (Huntington's chorea); (ix) Legionnaire's disease; (x) malaria; (xi) multiple sclerosis; (xii) muscular dystrophy; (xiii) myasthenia gravis; (xiv) necrotizing fasciitis; (xv) osteomyelitis; (xvi) poliomyelitis; (xvii) rabies; (xviii) sickle cell anemia; (xix) systemic lupus erythematosus (SLE); (xx) systemic sclerosis (scleroderma); (xxi) tetanus; or (xxii) tuberculosis? Yes No Yes No
- [20.] Have you EVER had any of the following: (i) Addison's disease (adrenal hypofunction); (ii) amyotrophic lateral sclerosis (Lou Gehrig's disease); (iii) cerebral palsy; (iv) cystic fibrosis; (v) Huntington's disease (Huntington's chorea); (vi) multiple sclerosis; (vii) muscular dystrophy; (viii) myasthenia gravis; (ix) poliomyelitis (x) sickle cell anemia; (xi) systemic lupus erythematosus (SLE); or (xii) systemic sclerosis (scleroderma)? Yes No Yes No
- [21.] In the last [2 months – 10 years] have you been diagnosed, treated or given medical advice by a physician or health care provider for any of the following : (i) Addison's disease (adrenal hypofunction); (ii) amyotrophic lateral sclerosis (Lou Gehrig's disease); (iii) cerebral palsy; (iv) cystic fibrosis; (v) Huntington's disease (Huntington's chorea); (vi) multiple sclerosis; (vii) muscular dystrophy; (viii) myasthenia gravis; (ix) poliomyelitis (x) sickle cell anemia; (xi) systemic lupus erythematosus (SLE); or (xii) systemic sclerosis (scleroderma)? Yes No Yes No

Medical Information (continued)

- [22.] Have you EVER had any of the following: (i) cerebrospinal meningitis (bacterial) (ii) diphtheria; (iii) encephalitis; (iv) Legionnaire's disease; (v) malaria; (vi) necrotizing fasciitis; (vii) osteomyelitis; (viii) rabies; (ix) tetanus; or (x) tuberculosis? Yes No Yes No
- [23.] In the last [2 months – 10 years] have you been diagnosed, treated or given medical advice by a physician or health care provider for any of the following : (i) cerebrospinal meningitis (bacterial) (ii) diphtheria; (iii) encephalitis; (iv) Legionnaire's disease; (v) malaria; (vi) necrotizing fasciitis; (vii) osteomyelitis; (viii) rabies; (ix) tetanus; or (x) tuberculosis? Yes No Yes No
- [24.] Have you EVER had any of the following: (i) a heart attack; (ii) coronary artery disease; or (iii) a stroke? Yes No Yes No
- [25.] In the last [2 months – 10 years] have you had any of the following: (i) cancer (except basal cell carcinoma); (ii) Hodgkin's disease; or (iii) leukemia? Yes No Yes No
- [26.] Have you EVER had any of the following: (i) cancer (except basal cell carcinoma); (ii) Hodgkin's disease; or (iii) leukemia? Yes No Yes No
- [27.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for any of the following: (i) cerebral palsy; (ii) cystic fibrosis; (iii) sickle cell anemia; or (iv) muscular dystrophy? Yes No Yes No
- [28.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for any of the following: (i) Addison's disease (adrenal hypofunction); (ii) amyotrophic lateral sclerosis (Lou Gehrig's disease); (iii) cerebral palsy; (iv) cystic fibrosis; (v) Huntington's disease (Huntington's chorea); (vi) multiple sclerosis; (vii) muscular dystrophy; (viii) myasthenia gravis; (ix) poliomyelitis (x) sickle cell anemia; (xi) systemic lupus erythematosus (SLE); or (xii) systemic sclerosis (scleroderma)? Yes No Yes No
- [29.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for any of the following: (i) Alzheimer's disease; (ii) mild cognitive impairment; (iii) Pick's disease; (iv) Lewy body disease; or (v) other form of dementia or pre-dementia? Yes No Yes No
- [30.] Have you EVER had kidney disease? Yes No Yes No
- [31.] Have you EVER had an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [32.] In the last [2 months – 10 years], have you had kidney disease? Yes No Yes No
- [33.] In the last [2 months – 10 years], have you had an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [34.] Have you EVER been diagnosed, treated, or given medical advice by a physician or other health care provider for any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; (vi) Alzheimer's disease; (vii) mild cognitive impairment; (viii) dementia; (ix) pre-dementia; or (x) an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [35.] In the last [2 months – 10 years], have you been diagnosed, treated, or given medical advice by a physician or other health care provider for any of the following: (i) a heart attack; (ii) coronary artery disease; (iii) cancer (except basal cell carcinoma); (iv) a stroke; (v) kidney disease; (vi) Alzheimer's disease; (vii) mild cognitive impairment; (viii) dementia; (ix) pre-dementia; or (x) an organ transplant (or been on the list for an organ transplant)? Yes No Yes No
- [36.] Have you smoked cigarettes, or used any other tobacco or nicotine product within the [12 - 24] months preceding the date of this enrollment form? Yes No Yes No

Give full details for "Yes" answers. [(additional space is provided [on next page/below], if needed)]

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

Medical Information (continued)

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

if you answered yes to question [7g], please provide most recent cholesterol results if you have had high cholesterol and most recent blood pressure results if you have had high blood pressure: Cholesterol results: _____ Date _____ Blood Pressure results _____ / _____ Date _____

[37.] Are any dependent children who are proposed for insurance currently Hospitalized* (as defined in question [3])? Yes No

[38.] Are you actively at work on a full-time basis performing all of the usual and customary duties of your job at the employer's place of business or an alternate place approved by the employer? Yes No

[39.] Your personal physician Date of and reason for last visit?
 Dr. Smith Flu vaccine, Nov. 2009
 Address Phone Number
 500 Washington Ave., AnyTown, YJ 111-222-3344

[40.] Your spouse's personal physician Date of and reason for last visit?
 Dr. Smith Flu vaccine, Nov. 2009
 Address Phone Number
 500 Washington Ave., AnyTown, YJ 111-222-3344

[41.] Have any of your biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age [70] with Alzheimer's disease, diabetes, heart disease, stroke, kidney disease, or cancer? If yes, please complete the following: Yes No

Relative	Condition	Age at Onset	Age at Death (if deceased)
Father			
Mother			
Siblings			

[42.] Have any of your spouse's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age [70] with Alzheimer's disease, diabetes, heart disease, stroke, kidney disease, or cancer? If yes, please complete the following: Yes No

Relative	Condition	Age at Onset	Age at Death (if deceased)
Father			
Mother			
Siblings]			

[BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)]			
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.			
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)]
[Jane Doe]	[Wife]	[1-5-70]	[100 Any St., Any Town, YJ, 12345]

DECLARATION SECTION

[The employee declares that he or she is actively at work on the date of this enrollment form. In addition if the employee is not actively at work on the scheduled Effective Date of the insurance requested, such insurance will not take effect until the employee returns to active work.] The employee [further] declares that no person proposed for coverage is covered by any Title XIX program (Medicaid or any similarly named program).

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

[For Changes Requested After Initial Enrollment Period Expires

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

[For Payroll Deduction Authorization By the Employee

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

Fraud Warning:

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: 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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

Signature(s): The [employee] must sign in all cases. [Each] person signing below **declares** that all the information given in this [enrollment form, including any medical questions,] is true and complete to the best of his/her knowledge and belief. [Each] person understands that this information will be used by MetLife to determine his or her insurability. [Each] person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

[John A. Doe]
[Employee] Signature

[John B. Doe]
Print Name

[10-1-2010]
Date (Mo./Day/Yr.)

[Proposed Insured(s) if other than [employee] and at least 18 years of age:

[Jane A. Doe]
Other Proposed Insured Signature

[Jane A. Doe]
Print Name

[10-1-2010]
Date (Mo./Day/Yr.)

[PLEASE RETAIN A COPY OF THE FULLY COMPLETED FORM FOR YOUR RECORDS; RETURN ORIGINAL TO:

**MetLife
Attn: Critical Illness
PO Box 5923
Bridgewater, NJ 08807-5923**

IF YOU HAVE ANY QUESTIONS, CALL METLIFE AT 1 800 GET-MET 8 (1-800-438-6388)]



Metropolitan Life Insurance Company
[200 Park Avenue], New York, New York [10010-3690]

MAJOR ORGAN TRANSPLANT RIDER

Group Policy No.: [XXXXXX-G]

Policyholder: [ABC Company]

Rider Effective Date: [January 1, XXXX]

The Certificate is changed as follows.

The following sections are added:

Major Organ Transplant Benefit Amount

For You:	[\$1,000-\$500,000]
For Your Spouse or Domestic Partner:	[\$1,000-\$500,000]
For Your Dependent Child:	[\$1,000-\$500,000]

CRITICAL ILLNESS BENEFITS FOR MAJOR ORGAN TRANSPLANT

If Major Organ Transplant First Occurs for [a Covered Person], while [such Covered Person is] insured under this rider, Proof of Major Organ Transplant must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Major Organ Transplant.

The Major Organ Transplant Benefit Amount shown above is payable for Major Organ Transplant that First Occurs [for a Covered Person] while coverage is in effect under this rider.

We will only pay for one Major Organ Transplant [per Covered Person] while coverage is in effect under this rider.

Payment of this benefit does NOT reduce the Total Benefit Amount.

Exclusions that Apply to Major Organ Transplant

We will not pay benefits for a Major Organ Transplant:

- performed outside the United States;
- involving organs received from non-human donors;
- involving implantation of mechanical devices or mechanical organs;

- involving stem cell generated transplants; or
- involving islet cell transplants.

Additional Proof Requirements for Major Organ Transplant

Proof of Major Organ Transplant requires submission of medical records evidencing that the Major Organ Transplant was deemed medically necessary by a Physician who is Board Certified in a medical specialty that is appropriate for the organ involved, and that either:

- [the Covered Person] has been placed on the Transplant List; or
- the Major Organ Transplant has been performed.

The Covered Condition for Major Organ Transplant will be deemed to Occur on the earlier of:

- [the date the Covered Person] is placed on the Transplant List; or
- the date that the Major Organ Transplant is performed.

Impact on Other Certificate Provisions

The following Certificate provisions and/or requirements are changed by this rider:

The “Definitions” section of the Certificate is changed as follows:

The definition of “Covered Condition” is deleted and replaced with the following:

Covered Condition means the following, as they are defined in the Certificate:

- Alzheimer’s Disease;
- Coronary Artery Bypass Graft;
- Full Benefit Cancer;
- Partial Benefit Cancer;
- Heart Attack or Stroke;
- Kidney Failure;
- Major Organ Transplant; or
- any of the Listed Conditions.

The following definition of “Major Organ Transplant” is added:

Major Organ Transplant means:

- the irreversible failure of [a Covered Person’s] heart, lung, pancreas, entire kidney or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either [such Covered Person has] been placed on the Transplant List or such transplant procedure has been performed;

- the irreversible failure of [a Covered Person's] liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary by a Physician and either [such Covered Person has] been placed on the Transplant List or such procedure has been performed; or
- the replacement of [a Covered Person's] bone marrow with bone marrow from [the Covered Person] or another human donor, which replacement is determined to be medically necessary by a Physician who is Board Certified in hematology or oncology in order to treat irreversible failure of [such Covered Person's] bone marrow.

The definition of "Occurs or Occurrence" is deleted and replaced with the following:

Occurs or Occurrence means:

- with respect to Full Benefit Cancer that [the Covered Person]
 1. experience[s] such Covered Condition;
 2. [is] Diagnosed with such Covered Condition; and
 3. such Diagnosis of Full Benefit Cancer is NOT a metastasis of a previously Diagnosed Full Benefit Cancer.
- with respect to Heart Attack or Stroke, Kidney Failure, Partial Benefit Cancer, or any of the Listed Conditions that [the Covered Person]:
 1. experience[s] such Covered Condition; and
 2. [is] Diagnosed with such Covered Condition.
- with respect to Coronary Artery Bypass Graft, that [the Covered Person] undergo[es] a Coronary Artery Bypass Graft.
- with respect to Major Organ Transplant, that [the Covered Person]
 1. is placed on the Transplant List; or
 2. undergo[es] such Major Organ Transplant.
- with respect to Alzheimer's Disease that [the Covered Person]:
 1. experience[s] such Covered Condition;
 2. [is] Diagnosed with such Covered Condition; and
 3. all other etiologies have been ruled out by a Neurologist, Geriatrician or a Neuropsychologist.

The definition of "Total Benefit Amount" is deleted and replaced with the following:

Total Benefit Amount means the maximum aggregate amount, as specified in the Schedule of Insurance, that We Will pay for any and all Covered Conditions combined[, per Covered Person, per lifetime,] as provided under this Certificate [or any Certificate it replaces]. The Total Benefit Amount does not include [Supplemental Benefits or] the Major Organ Transplant Benefit Amount.

The following definition of "Transplant List" is added:

Transplant List means the Organ Procurement and Transportation Network (OPTN) list.

The "Reduction on Account of Prior Claims Paid" provision is changed as follows:

REDUCTION ON ACCOUNT OF PRIOR CLAIMS PAID

We will reduce what We pay for a claim so that the amount We pay, when combined with amounts for all claims We have previously paid [for the same Covered Person], does not exceed the Total Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition. This provision does not apply to [claim payments for Supplemental Benefits or] payment of the Major Organ Transplant Benefit Amount.

Termination of this Rider:

This rider will end on the earlier of: (1) the date insurance under Your Certificate ends; or (2) the date the Major Organ Transplant Benefit Amount has been paid [for all Covered Persons].

Effective Date of this Rider:

This rider takes effect on the Rider Effective Date shown above.

In all other respects, the provisions and conditions of the Certificate remain the same. This rider is subject to the terms and provisions of the Certificate. It is to be attached to and made a part of the Certificate.

SERFF Tracking Number: META-126840677 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 46939
 Company Tracking Number: NY10-13 KC (LW)
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Accident and Health Insurance
 Project Name/Number: GCERT10-CI series/NY10-13 KC

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/08/2010	Rate Pages	GCERT10-CI, et al	New		Critical Illness Group 30 Rate Manual Section XXXVI(B) V1 - AR.pdf

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

I. A. Benefits for Covered Conditions

The group policy provides a lump-sum benefit amount, subject to the terms and conditions of the Group Policy, if a Covered Condition Occurs while a Covered Person is insured under the Policy. Coverage, defined as the Benefit Amount, may be available under this form in amounts between \$1,000 and \$500,000.

Depending on the Covered Conditions, benefit paid on First Occurrence varies between 25% and 100% of the Benefit Amount. Benefit paid on Re-Occurrence varies between 0% and 50% of the Benefit Amount. Maximum benefit that may be paid due to Covered Conditions is limited to the Total Benefit Amount, which may be available between \$2,000 and \$1,000,000.

Benefits for Covered Conditions are summarized as follows.

Covered Condition	Initial Benefit	Re-Occurrence Benefit
Alzheimer's Disease	100% of Benefit Amount	NONE
Coronary Artery Bypass Graft	100% of Benefit Amount	50% of Benefit Amount
Full Benefit Cancer	100% of Benefit Amount	50% of Benefit Amount
Partial Benefit Cancer	25% of Benefit Amount	12.5% of Benefit Amount
Heart Attack	100% of Benefit Amount	50% of Benefit Amount
Kidney Failure	100% of Benefit Amount	NONE
Stroke	100% of Benefit Amount	50% of Benefit Amount
Any one of Listed Conditions	25% of Benefit Amount	NONE*

*There may be a Re-Occurrence Benefit for an Occurrence of rabies.

List Conditions

Addison's disease (adrenal hypofunction)	amyotrophic lateral sclerosis (Lou Gehrig's disease)
cerebrospinal meningitis (bacterial)	cerebral palsy
cystic fibrosis	diphtheria
encephalitis	Huntington's disease (Huntington's chorea)
Legionnaire's disease	malaria
multiple sclerosis (definitive diagnosis)	muscular dystrophy
myasthenia gravis	necrotizing fasciitis
osteomyelitis	poliomyelitis
rabies	sickle cell anemia (excluding sickle cell trait)
systemic lupus erythematosus (SLE)	systemic sclerosis (scleroderma)
tetanus	tuberculosis

B. Supplemental Benefits

The following supplemental benefits may be provided:

- (a) Health Screening Benefit,
- (b) Lodging Benefit,
- (c) Transportation Benefit,
- (d) Evaluation Benefit, and
- (e) NCI Cancer Center Benefit.

Payment of the supplemental benefits does not reduce the Total Benefit Amount.

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

C. Waiver of Premiums Provision

A Waiver of Premiums provision may be provided. Under this provision, if an employee who becomes Disabled and meets the terms and conditions as specified in the Certificate while coverage is in effect, premiums of Covered Persons on the same certificate will be waived.

D. Major Organ Transplant Rider

A Major Organ Transplant Rider may be provided. The Major Organ Transplant Benefit Amount will be paid on First Occurrence for a Covered Person while coverage is in effect under this rider.

Payment of this benefit does not reduce the Total Benefit Amount.

Coverage may be subject to a waiting period, a benefit suspension period, and/or pre-existing condition exclusions for all Covered Conditions in accordance with the terms of the Group Policy and Certificate.

Coverage may be offered on a non-contributory basis with premiums paid by the group policyholder or on a contributory basis with premiums paid by group certificate holders. Coverage may also be provided for dependent spouses and dependent children of employees.

II. Policies Providing Benefits with Premiums to be Paid by the Group Policyholder

A. Standard Monthly Premium Rates for Employee Coverage

The standard monthly premium rates per \$1,000 of coverage for each group applicable to policyholder paid employee coverage will be computed based on the demographics of the group, the principal industry of employment of the group, the underwriting method, and other relevant factors according to the following algorithm.

(a) Determine monthly premium rate per \$1,000 of coverage for Covered Conditions

Step a1: Multiply the base monthly premium rates shown in Table XXXVI(B).1 by appropriate Underwriting Adjustment Factors shown in Table XXXVI(B).2. Name this adjusted monthly premium rates table as Table A.

Step a2: Cross multiply Table A from Step a1 with the applicable proposed coverage amounts (in thousands) determined using a complete census of the insured classes of employees or eligible classes of employees provided by the group policyholder. Sum the result obtained for each age and gender cell across all age and gender cells.

Step a3: Sum the total proposed coverage amounts across the entire census used in Step a2.

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Step a4: Divide the result of Step a2 by the result of Step a3. This is the baseline monthly premium rate per \$1,000 of coverage for Covered Conditions.

Step a5. Multiply the result of Step a4 by the applicable Waiting Period Adjustment Factor from Table XXXVI(B).3.

Step a6. Multiply the result of Step a5 by the applicable Pre-existing Condition Exclusion Adjustment Factor from Table XXXVI(B).4.

Step a7: Multiply the result of Step a6 by the applicable Industry Adjustment Factor from Table XXXVI(B).5.

Step a8: Based on the ratio between Total Benefit Amount and Benefit amount, determine the Re-Occurrence Benefit Premium Adjustment Factor from Table XXXVI(B).6. Interpolate if necessary. Multiply the results from Step a7 by this factor.

Step a9: Adjust the results from Step a8 to reflect an increasing trend in claim cost. The premium rate derived from Step a8 will be multiplied by $(\text{Trend Factor})^T$, where T is the elapsed time (measured in years) from 7/1/2007 to the mid-point of the prospective policy period. The applicable Trend Factor is shown in Table XXXVI(B).20 of this section.

(b) Determine monthly premium rate per \$1,000 of coverage for Supplemental Benefits

Step b1: Determine annual premiums for the Health Screening Benefit from Table XXXVI(B).7. Interpolate if necessary.

Step b2: Determine annual premiums for the Lodging Benefit from Table XXXVI(B).8. Interpolate if necessary.

Step b3: Determine annual premiums for the Transportation Benefit from Table XXXVI(B).9. Interpolate if necessary.

Step b4: Determine annual premiums for the Evaluation Center Benefit from Table XXXVI(B).10. Interpolate if necessary.

Step b5: Determine annual premiums for the NCI Cancer Center Benefit from Table XXXVI(B).11. Interpolate if necessary.

Step b6: Sum the results in Steps b1-b5, then divide by coverage amount (in thousand) and by 12 (twelve). This is the monthly premium rate per thousand for Supplemental Benefits.

Premium rates in Table XXXVI(B).7 to Table XXXVI(B).11 were derived based on typical benefit utilization assumptions. If credible utilization information of these

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

supplemental benefits is available for a specific group, use the following formula instead of tabular amounts in Table XXXVI(B).7 to Table XXXVI(B).11 in Steps b1-b5.

$$\text{Annual Premiums} = \text{Annual Benefit Amount} * \text{Utilization} / \text{Pricing Loss Ratio}$$

(c) Determine monthly premium rate per \$1,000 of coverage for Major Organ Transplant benefit

Step c1: Repeat Steps a1-a9 and use Table XXXVI(B).12 instead of Table XXXVI(B).1 in determining monthly premium rate per \$1,000 coverage for the Major Organ Transplant benefit if provided. Also, skip Step a8 since there is no Re-Occurrence benefit for the Major Organ Transplant rider.

(d) Determine total premium rates per \$1,000 of coverage for all benefits

Step d1: sum premium rates in Steps a9, b6 and c1.

Step d2: If Waiver of Premiums benefit is provided, multiply the results from Step d1 by the Premiums Adjustment Factor from Table XXXVI(B).13.

Step d3: Multiply the results from Step d2 by the Premiums Adjustment Factor from Table XXXVI(B).14 for the number of years with premium rate guarantee. Interpolate if necessary.

Step d4: Multiply the result of Step d3 by the appropriate Volume Adjustment Factor from Table XXXVI(B).15. In determining total annual premiums, premiums for Employee coverage, premiums for dependent spouses coverage (if provided, see Section II.B) and premiums for dependent children coverage (if provided, see Section II.C) are combined.

Step d5: Broker commissions payable in accordance with Table XXXVI(B).21 of this section will be included in the final premium rates if applicable.

Step d6: Round the result of Step d5 to 3 decimal places to determine the final result.

B. Standard Monthly Premium Rates for Dependent Spouses Coverage

Repeat Steps a1-d6 in Section II.A to determine the per \$1,000 monthly premium rates for dependent spouses. Use dependent spouses census, instead of employee census, in Step a2.

In the event a dependent spouses census is not available, an employee census may be used. In such instances, assume that

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

- 40% of employees have spouses,
- spouse is of the opposite sex of the employee, and
- female spouses are three (3) years younger than male employees, and male spouses are three (3) years older than female employees.

C. Standard Monthly Premium Rates for Dependent Children Coverage

Repeat Steps a1-d6 in Section II.A to determine the per \$1,000 monthly premium rates for dependent children. Use monthly premium rates for Dependent Child, Table XXXVI(B).19, instead of Table XXXVI(B).1 in Step a1, and, use dependent children census instead of employee census, in Step a2. Also skip Step a7 (Industry Adjustment).

If dependent children census is not available, assume 30% of employees have dependent children.

III. Policies Providing Voluntary Benefits with Premiums to be Paid by the Participants

A. Monthly Premium Rates for Employee Coverage

Uni-sex rates per \$1,000 of voluntary coverage will be developed by smoking status in 5-year age brackets for each group policy. The premiums charged to Covered Persons will be based on the actual amount of coverage elected by the Covered Person, the Covered Person's attained age, and the Covered Person's smoking status. A schedule of uni-smoker rates may also be available.

A premium schedule of monthly unisex rates per \$1,000 of coverage for each group applicable to voluntary employee coverage will be computed based on the demographics of the group, the principal industry of employment of the group, the underwriting method, and other relevant factors according to the following algorithm.

(a) Determine monthly premium rates per \$1,000 of coverage for Covered Conditions

Step a1: Determine the expected distribution of employee coverage between male and female employees. If a group specific employee census is available, the percentage of males and females within the overall group should be determined directly from the data. If no census is available, the expected overall percentage of male employees should be determined by using the factors in Table XXXVI(B).5 and the Standard Industrial Classification ("SIC") code of the group. The percentage of female employees is then calculated by subtracting the percentage of male employees thus determined from 1.

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Step a2: Using the male and female percentages determined in Step a1, blend the male and female non-smoker base rates from Table XXXVI(B).16 within each 5-year age bracket using the following formula:

for each age bracket i

$$\begin{aligned} &\text{Blended Non Smoker (“NS”) Base Rate;} \\ &= (\% \text{ male}) \times (\text{male NS base rate})_i + (\% \text{ female}) \times (\text{female NS base rate})_i. \end{aligned}$$

Step a3: Using the male and female percentages determined in Step a1, blend the male and female smoker base rates from Table XXXVI(B).16 within each 5-year age bracket using the following formula:

for each age bracket i

$$\begin{aligned} &\text{Blended Smoker (“S”) Base Rate;} \\ &= (\% \text{ male}) \times (\text{male S base rate})_i + (\% \text{ female}) \times (\text{female S base rate})_i. \end{aligned}$$

Step a4: Adjust the blended 5-yr bracket rates in Step a2 and Step a3 by the appropriate Underwriting Adjustment Factors, as shown in Table XXXVI(B).18, based on anticipated participation rate and underwriting method.

Steps a5-a9: Follow Steps a5-a9 in Section II.A to determine the final monthly premium rates per \$1,000 coverage. In each of the steps, apply adjustments to smoker and non-smoker blended 5-yr bracket rates instead of to a single premium rate as in Section II.A.

(b) Determine monthly premium rates per \$1,000 of coverage for Supplemental Benefits

Follow Steps b1-b6 in Section II.A to determine monthly premium rates per \$1,000 of coverage for Supplemental Benefits.

(c) Determine monthly premium rates per \$1,000 of coverage for Major Organ Transplant benefit

Follow Step c1 in Section II.A to determine monthly premium rates per \$1,000 of coverage for Major Organ Transplant benefit.

(d) Determine total premium rates per \$1,000 of coverage for all benefits

Follow Steps d1-d6 in Section II.A to determine the final monthly premium rates per \$1,000 of coverage. In each of the steps, apply adjustments to smoker and non-smoker blended 5-yr bracket rates instead of to a single premium rate as in Section II.A.

When participation level and smoker/non-smoker percentage are needed in estimating total annual premiums or underwriting selection effect, use the current actual participation and non-

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

smoker/smoker percentage for existing groups if credible. For brand new prospects, assume 10%-25 % participation for guaranteed issue cases, 5%-15% for simplified issue cases, and 1%-3% for full underwriting cases. Also assume non-smokers represent 75% of the group, and smokers represent 25% of the group. Underwriters may use discretion in modifying the participation assumption if more reliable information is available for any particular group.

If the group policyholder prefers a uni-smoker rate structure, a schedule of uni-smoker rates can be developed. Smokers and non-smokers rates from Step d6 can be blended based on anticipated smokers/non-smokers participant ratio.

B. Monthly Premium Rates for Dependent Spouses Coverage

The steps to compute 5-year bracket rates for dependent spouses are the same as Steps a1-d6 in Section III.A, except the following:

- Use dependent spouses census instead of employee census. If dependent spouses census is not available, use employee census and assume spouses are of the opposite sex of the employees. Also assume 40% of employees have dependent spouses.
- Use Table XXXVI(B).17 instead of Table XXXVI(B).16 in Step a3 as the base 5-year bracket rates.

C. Standard Monthly Premium Rates for Dependent Children Coverage

Repeat Steps a1-d6 in Section III.A to determine the per \$1,000 monthly premiums for dependent children. Use monthly premium rates for Dependent Child Table XXXVI(B).19 instead of Table XXXVI(B).16, and, use dependent children census instead of employee census, in Step a2. Also skip Step a7 (Industry Adjustment).

If dependent children census is not available, assume 30% of employees have dependent children.

- IV. For administration ease, premium rates developed in Section III may be expressed in different (but equivalent) forms as follows.

A. Premium rates based on employees' ages

Premium rates developed in Section III are 5-year age bracket rates, separate for employees and dependent spouses, based on the covered person's age. Premium rates for dependent spouses may also be expressed to be based on employees' ages as follows.

If a census of the dependent spouses is available, use the census to determine the average age difference between employees and dependent spouses. Re-bracket dependent spouses age

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

bands to be the same as employees' age bands by interpolating linearly premium rates for dependent spouses at the new age bands based on employees' ages.

If a census for dependent spouses is not available, assume spouses are of the opposite sex of the employees, and that female spouses are three (3) years younger than male employees, and male spouses are three (3) years older than female employees in carrying out the calculations.

B. Premium rates based on number of dependents

Premium rates developed in Section III may also be expressed as 5-year age bracket rates for employee only (i.e., no dependent), employee plus one dependent, employee plus two dependents, and employee plus family (three or more dependents).

If a census for dependent spouses and dependent children is available, the census will be used to develop composite rates between dependent spouses and children after translating spouses rates to be based on employees' ages as described in Section IV.A.

If a census is not available, assume the composition of covered persons as follows in developing composite rates for number of dependents.

- employee only: 50%
- employee with dependent spouse: 20%
- employee with dependent children: 10%
- employee with dependent spouse and children: 20%

Also assume 50% of dependent children coverage cases covers one child, and, 50% of dependent children coverage cases covers two or more children.

C. Premium rates blended between different underwriting methods

Coverage may be offered to a covered person on different underwriting basis (e.g., guaranteed issue for the first \$10,000 coverage and full underwriting for the next \$20,000 coverage). Premium rates developed based on different underwriting methods may be blended based on the average coverage amount with respect to each underwriting method for administration ease.

- V. To convert monthly premiums developed in this section to a mode other than monthly, multiply the final rates developed in accordance with this section by the factors from Table XXXVI(B).22 of this rate manual.
- VI. The provisions of a particular employer's plan may call for variations in approved benefit designs not explicitly outlined. Appropriate interpolation or extrapolation methods will be used to determine premium rates for plans or benefits with specifications different from those shown in this section.

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

- VII. When group insurance coverage not presently in force with MetLife is transferred to MetLife from another carrier, the premium rates otherwise applicable for such coverage in accordance with this section may be adjusted for the experience incurred with the prior carrier to the extent that such carrier's experience data is reliable and credible. The completeness, format, and consistency of all available information will be considered in determining the reliability of the prior carrier's experience.
- VIII. This coverage may be subject to prospective experience rating. The premium rates otherwise applicable for such coverage in accordance with this section may be adjusted for the experience incurred with MetLife to the extent that such experience data is reliable and credible.

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

**Table XXXVI(B).1 – Base Monthly Premium Rates per \$1,000 Benefit Amount
For Non-Contributory Coverage**

Age	Male	Female	Age	Male	Female
17	0.034	0.034	59	2.666	1.795
18	0.039	0.039	60	2.903	1.944
19	0.043	0.044	61	3.181	2.096
20	0.049	0.050	62	3.480	2.261
21	0.054	0.056	63	3.822	2.447
22	0.059	0.062	64	4.170	2.643
23	0.065	0.070	65	4.571	2.852
24	0.071	0.077	66	4.953	3.059
25	0.077	0.085	67	5.358	3.271
26	0.083	0.092	68	5.742	3.497
27	0.089	0.100	69	6.116	3.783
28	0.095	0.110	70	6.556	4.107
29	0.105	0.121	71	7.056	4.489
30	0.117	0.133	72	7.580	4.963
31	0.137	0.148	73	8.110	5.481
32	0.159	0.163	74	8.635	6.054
33	0.186	0.185	75	9.192	6.630
34	0.213	0.207	76	9.687	7.199
35	0.240	0.229	77	10.322	7.796
36	0.267	0.251	78	10.902	8.383
37	0.294	0.273	79	11.581	9.049
38	0.327	0.304	80	12.203	9.773
39	0.364	0.338	81	12.946	10.536
40	0.407	0.375	82	13.552	11.216
41	0.454	0.415	83	13.968	11.872
42	0.505	0.457	84	14.551	12.442
43	0.575	0.513	85	15.104	12.903
44	0.645	0.568	86	15.436	13.343
45	0.713	0.622	87	15.851	13.674
46	0.784	0.677	88	16.324	13.957
47	0.853	0.733	89	16.652	14.182
48	0.950	0.794	90	16.937	14.317
49	1.052	0.860	91	17.103	14.486
50	1.160	0.930	92	17.257	14.642
51	1.276	1.005	93	17.416	14.802
52	1.396	1.083	94	17.581	14.967
53	1.556	1.177	95	17.750	15.137
54	1.718	1.270	96	17.925	15.313
55	1.878	1.364	97	18.106	15.494
56	2.052	1.466	98	18.293	15.680
57	2.228	1.568	99	18.485	15.873
58	2.441	1.677	100	18.683	16.071

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

**Table XXXVI(B).2 – Non-Contributory Coverage
Underwriting Adjustment Factors**

Age	Guaranteed Issue	Simplified Issue	Full Underwriting
<25	1.03	1.00	0.90
25 - 29	1.03	1.00	0.90
30 - 34	1.03	1.00	0.90
35 - 39	1.03	1.00	0.90
40 - 44	1.09	1.00	0.90
45 - 49	1.14	1.00	0.90
50 - 54	1.15	1.00	0.90
55 - 59	1.16	1.00	0.90
60 - 64	1.17	1.00	0.90
65 - 69	1.18	1.00	0.90
70 - 74	1.22	1.00	0.90
75 - 79	1.27	1.00	0.90
80 - 84	1.30	1.00	0.90
85+	1.32	1.00	0.90

Table XXXVI(B).3 – Waiting Period Adjustment Factors

Other Covered Conditions	Full and Partial Benefit Cancers			
	0 Days	30 Days	60 Days	90 Days
0 Days	1.012	N/A	N/A	N/A
30 Days	N/A	1.000	0.990	0.980
60 Days	N/A	0.995	0.983	0.973
90 Days	N/A	0.987	0.977	0.967

Table XXXVI(B).4 – Pre-Existing Condition Exclusion Adjustment Factors

Limitation in Months (number of months before / after the effective date of coverage)	Adjustment Factor
0 / 0	1.08
3 / 6	1.05
6 / 6	1.03
3 / 12	1.03
6 / 12	1.02
9 / 12	1.01
12 / 12	1.00

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Table XXXVI(B).5 – Industry Adjustment Factors

SIC*	Industry Description	Typical Male Percentage	Factors
100	Agricultural Production, Crops	75%	1.05
200	Agricultural Production, Livestock	75%	1.05
700	Agricultural Services, N.E.C	60%	0.95
800	Forestry	75%	0.95
900	Fishing, Hunting, And Trapping	90%	0.95
1000	Metal Mining	90%	1.25
1100	Anthracite Mining	90%	1.25
1200	Coal Mining	90%	1.05
1220	Bituminous Coal	90%	1.10
1230	Anthracite Mining	90%	1.25
1300	Oil And Gas Extraction	85%	1.10
1400	Nonmetallic Mining And Quarrying, Except Fuel	85%	1.05
1500	General Building Contractors	90%	1.10
1600	Heavy Construction Contractors	90%	1.15
1700	Special Trade Contractors	90%	1.05
2000	Food And Kindred Products	70%	1.00
2100	Tobacco Manufacturers	65%	1.25
2200	Textile Mill Products	55%	1.05
2300	Apparel And Other Finished Textile Products	30%	0.90
2400	Lumber And Wood Products, Except Furniture	85%	1.15
2500	Furniture And Fixtures	70%	0.90
2600	Paper And Allied Products	75%	0.90
2700	Printing, Publishing, And Allied Products	55%	1.00
2710	Newspaper Publishing And Printing	50%	1.00
2750	Commercial Printing	60%	1.05
2800	Chemicals And Allied Products	70%	0.95
2900	Petroleum And Coal Products	90%	1.05
3000	Rubber And Miscellaneous Plastics Products	70%	0.90
3100	Leather And Leather Products	50%	1.05
3140	Footwear, Except Rubber And Plastic	45%	1.00
3200	Stone, Clay, Glass, And Concrete Products	80%	1.20
3290	Miscellaneous Nonmetallic Mineral And Stone Products	80%	1.20
3300	Primary Metal Industries	85%	1.20
3310	Blast Furnaces, Steelworks, Rolling, And Finishing Mills	90%	1.20
3320	Iron And Steel Foundries	90%	1.25
3400	Fabricated Metal Industries	75%	1.10
3440	Fabricated Structural Metal Products	85%	1.20
3500	Machinery And Computing Equipment	75%	1.00
3530	Construction And Material Handling Machines	85%	0.95
3540	Metal Working Machinery	85%	0.95
3550	Machinery And Computing Equipment	75%	1.00
3560	General Industrial Machinery	75%	1.05

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

SIC*	Industry Description	Typical Male Percentage	Factors
3570	Computers And Related Equipment	65%	0.90
3580	Service Industry Machines	65%	1.05
3600	Electrical Machinery, Equipment, And Supplies	65%	1.05
3610	Electrical Test and Distributing Equipment	65%	0.95
3620	Electrical Industrial Apparatus	65%	0.95
3630	Household Appliances	65%	0.95
3660	Radio, T.V., And Communication Equipment	65%	0.90
3670	Electrical Machinery, Equipment, And Supplies, N.E.C. And Not Specified	65%	0.90
3700	Transportation Equipment	75%	1.05
3710	Motor Vehicles And Motor Vehicle Equipment	75%	1.10
3720	Aircraft And Parts	75%	0.95
3800	Professional And Photographic Equipment, And Watches	70%	0.95
3900	Miscellaneous And Not Specified Manufacturing Industries	60%	0.95
4000	Railroads	90%	0.95
4100	Bus Service And Urban Transit	70%	1.25
4200	Trucking & Warehousing	85%	1.10
4210	Trucking, Local & Long Distance	85%	1.30
4300	U.S. Postal Service	60%	1.00
4400	Water Transportation	80%	1.15
4500	Air Transportation	65%	1.05
4600	Gas And Steam Supply Systems	75%	1.10
4700	Services Incidental To Transportation	40%	1.10
4800	Communications	55%	0.95
4900	Utilities And Sanitary Services	80%	0.95
4910	Electric Light And Power	80%	0.95
4920	Gas And Steam Supply Systems	75%	0.95
4930	Electric and gas, and other combinations	75%	0.95
5000	Durable Goods	70%	1.00
5100	Non-Durable Goods	70%	0.95
5110	Paper and Paper Products	55%	0.95
5120	Drugs and Druggists' Sundries	55%	0.95
5130	Apparel, Piece Goods and Notions	50%	0.95
5190	Miscellaneous Non-Durable Goods	65%	0.95
5200	Lumber And Building Material Retailing	70%	1.10
5300	Miscellaneous General Merchandise Stores	45%	0.95
5310	Department Stores	35%	0.90
5400	Food Stores, N.E.C	50%	1.05
5410	Grocery Stores	50%	1.05
5500	Motor Vehicle Dealers	80%	1.00
5600	Apparel And Accessory Stores, Except Shoe Stores	25%	1.00
5660	Shoe Stores	40%	1.00
5700	Furniture And Home Furnishings Stores	65%	1.00
5800	Eating And Drinking Places	50%	1.10

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

SIC*	Industry Description	Typical Male Percentage	Factors
5900	Drug Stores	35%	0.90
6000	Banking	30%	0.90
6010	Federal Reserve Banks	30%	0.90
6020	Commercial & Stock Savings Banks	30%	0.90
6100	Credit Agencies, N.E.C	40%	0.95
6200	Security, Commodity Brokerage, And Investment Companies	60%	0.95
6300	Insurance Carriers	40%	1.05
6400	Insurance Agents, Brokers, & Services	40%	0.95
6500	Real Estate, Including Real Estate-Insurance Offices	55%	0.95
6600	Combination Real Estate, Insurance, Etc.	65%	1.00
6700	Holding And Other Investment Offices	60%	1.05
7000	Hotels And Motels	45%	1.10
7200	Personal Services, Except Private Household	35%	1.05
7300	Business, Automobile, And Repair Services	65%	0.90
7370	Computer And Data Processing Services	65%	0.90
7500	Automotive Repair And Related Services	90%	1.20
7600	Miscellaneous Repair Services	85%	1.15
7800	Theaters And Motion Pictures	60%	1.05
7840	Video Tape Rental Stores	40%	1.05
7900	Entertainment And Recreation Services	55%	1.00
8000	Professional And Related Services	30%	0.90
8100	Legal Services	45%	0.90
8200	Educational Services	30%	0.90
8210	Elementary And Secondary Schools	25%	0.90
8220	Colleges And Universities	50%	0.90
8300	Social Services, N.E.C	30%	1.15
8400	Museums, Art Galleries, And Zoos	40%	1.10
8600	Membership Organizations, N.E.C	30%	1.05
8610	Business Associations	30%	1.05
8630	Labor Unions	60%	1.20
8660	Religious Organizations	50%	0.90
8700	Engineering/Accounting/R & D	80%	0.90
8710	Engineering & Architectural Services	80%	0.90
8720	Accounting, Auditing, And Bookkeeping Services	40%	0.90
8730	Research, Development, And Testing Services	55%	0.90
8800	Private Households	10%	1.00
8900	Miscellaneous Professional And Related Services	45%	0.90
8910	Engineering & Architectural Services	80%	0.90
8920	Non-Commercial Research	55%	0.90
8930	Accounting And Auditing	40%	0.90
9100	Executive And Legislative Offices	35%	1.05
9200	Justice, Public Order, And Safety	70%	1.10
9300	Public Finance, Taxation, And Monetary Policy	35%	1.10
9400	Administration Of Human Resources Programs	35%	1.00

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

SIC*	Industry Description	Typical Male Percentage	Factors
9500	Administration Of Environmental Quality And Housing Programs	60%	1.00
9600	Administration Of Economic Programs	55%	1.00
9700	National Security And International Affairs	60%	1.05
9900	Non-Classifiable Establishments	60%	1.00

* The appropriate NAICS Code may be used in lieu of the SIC Code

Table XXXVI(B).6 – Re-Occurrence Benefit Premium Adjustment Factors

Total Benefit Amount divided by Benefit Amount	Adjustment Factor
100%	1.000
150%	1.050
200%	1.100
250%	1.145
300%	1.185

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Table XXXVI(B).7 – Health Screening Benefit Annual Premiums

Annual Benefit Amount	Annual Premiums
\$50	\$8.33
\$75	\$13.75
\$100	\$20.00
\$150	\$35.00
\$200	\$50.00

Table XXXVI(B).8 – Lodging Benefit Annual Premiums

Lodging Benefit Amount per Day	Annual Premiums
\$100	\$3.10

Table XXXVI(B).9 –Transportation Benefit Annual Premiums

Maximum Amount per Round Trip	Annual Premiums
\$1000	\$2.80
\$1200	\$3.37
\$1500	\$4.10
\$2000	\$5.20
\$2500	\$6.25

Table XXXVI(B).10 –Evaluation Benefit Annual Premiums

Benefit Amount (Consultation Benefit / Mileage Benefit)	Annual Premiums
\$500 / \$250	\$7.5
\$1000 / \$500	\$15.0

Table XXXVI(B).11 –NCI Cancer Center Benefit Annual Premiums

Benefit Amount (Consultation Benefit / Mileage Benefit)	Annual Premiums
\$500 / \$250	\$5.0
\$1000 / \$500	\$10.0

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

**Table XXXVI(B).12 – Monthly Premium Rates per \$1,000 Benefit Amount
For Major Organ Transplant Benefit**

Age	Male	Female
All Ages	0.012	0.007

**Table XXXVI(B).13 – Waiver of Premiums Benefit
Premium Adjustment Factors**

Months Continuously Disabled before Benefit Available	Premium Adjustment Factor
3	1.12
6	1.10
12	1.08

**Table XXXVI(B).14 – Rate Guarantee
Premium Adjustment Factors**

Number of Years Guaranteed	Premium Adjustment Factor
1	1.00
3	1.02
5	1.05

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Table XXXVI(B).15 – Volume Adjustment Factors

Annual Premiums	Volume Adjustment Factor Non-Contributory	Volume Adjustment Factor Contributory
\$30,000 or less	1.16	1.43
\$30,001 to \$50,000	1.01	1.24
\$50,001 to \$100,000	0.96	1.19
\$100,001 to \$250,000	0.90	1.11
\$250,001 to \$500,000	0.86	1.06
\$500,001 to \$1,000,000	0.84	1.04
\$1,000,001 to \$3,000,000	0.83	1.02
\$3,000,001 to \$5,000,000	0.82	1.01
\$5,000,001 to \$10,000,000	0.82	1.01
\$10,000,001 or more	0.82	1.01

Footnotes to Table XXXVI(B).15:

- 1.) For the following additional expense items, the increase to premium would fall in the range of 0.1% to 1.5% for each item.
 - a.) Customized marketing material
 - b.) Customized proposals
 - c.) More complex administrative structure (due to multiple separations, etc.)
 - d.) Customized quotation and underwriting tools
 - e.) Customized legal and contractual arrangements
 - f.) Customized billing and collections procedures
 - g.) Special customer reporting
 - h.) Special customer meetings
 - i.) Special customer service requirements
 - j.) Special printing requirements
 - k.) Customized administration manuals
 - l.) Special solicitation materials
 - m.) Performance guarantees

- 2.) MetLife may enter into agreements with third parties under which the allowance, if any, paid to the third party for performing certain functions is less than the corresponding allowance implied by the factors above. MetLife may reduce the premium up to 1.5% for each of the following performed by a third party.
 - a.) Billing and collection
 - b.) Preparation of quotes
 - c.) Payment of claims
 - d.) Payment of broker commissions
 - e.) Marketing and promotion
 - f.) Issuance of certificates

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

**Table XXXVI(B).16 – Base Monthly Premium Rates per \$1,000 Benefit Amount
For Voluntary Coverage of Employees**

Age	Male Non-Smoker	Male Smoker	Female Non-Smoker	Female Smoker
< 25	0.066	0.111	0.072	0.124
25 to 29	0.076	0.128	0.084	0.147
30 to 34	0.136	0.229	0.137	0.243
35 to 39	0.251	0.422	0.228	0.407
40 to 44	0.431	0.727	0.381	0.684
45 to 49	0.725	1.237	0.610	1.101
50 to 54	1.180	2.045	0.902	1.627
55 to 59	1.873	3.290	1.307	2.351
60 to 64	2.916	5.171	1.888	3.380
65 to 69	4.477	8.002	2.736	4.877
70 to 74	6.327	11.338	4.155	7.387
75 to 79	8.629	15.400	6.532	11.587
80 to 85	11.311	20.274	9.376	16.738
> 85	13.826	25.130	11.809	21.301

**Table XXXVI(B).17 – Base Monthly Premium Rates per \$1,000 Benefit Amount
For Voluntary Coverage of Dependent Spouses**

Age	Female Spouse (Male Employee) Non-Smoker	Female Spouse (Male Employee) Smoker	Male Spouse (Female Employee) Non-Smoker	Male Spouse (Female Employee) Smoker
< 25	0.072	0.124	0.066	0.111
25 to 29	0.084	0.147	0.076	0.128
30 to 34	0.137	0.243	0.136	0.229
35 to 39	0.228	0.407	0.251	0.422
40 to 44	0.381	0.684	0.431	0.727
45 to 49	0.610	1.101	0.725	1.237
50 to 54	0.902	1.627	1.180	2.045
55 to 59	1.307	2.351	1.873	3.290
60 to 64	1.888	3.380	2.916	5.171
65 to 69	2.736	4.877	4.477	8.002
70 to 74	4.155	7.387	6.327	11.338
75 to 79	6.532	11.587	8.629	15.400
80 to 85	9.376	16.738	11.311	20.274
> 85	11.809	21.301	13.826	25.130

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

**Table XXXVI(B).18 – Contributory Coverage
Underwriting Adjustment Factors**

Age \ Participation	Guaranteed Issue						Simplified Issue	Full UW
	< 5%	[5, 10%)	[10-15%)	[15-20%)	[20-30%)	>= 30%		
<25	1.07	1.04	1.03	1.03	1.03	1.03	1.00	0.90
25 - 29	1.07	1.04	1.03	1.03	1.03	1.03	1.00	0.90
30 - 34	1.07	1.04	1.03	1.03	1.03	1.03	1.00	0.90
35 - 39	1.08	1.04	1.04	1.04	1.03	1.03	1.00	0.90
40 - 44	1.21	1.12	1.10	1.10	1.09	1.09	1.00	0.90
45 - 49	1.33	1.19	1.16	1.15	1.14	1.14	1.00	0.90
50 - 54	1.36	1.21	1.18	1.17	1.16	1.15	1.00	0.90
55 - 59	1.38	1.22	1.19	1.18	1.17	1.16	1.00	0.90
60 - 64	1.41	1.24	1.20	1.19	1.18	1.17	1.00	0.90
65 - 69	1.44	1.26	1.22	1.20	1.19	1.18	1.00	0.90
70 - 74	1.53	1.31	1.26	1.25	1.24	1.22	1.00	0.90
75 - 79	1.65	1.38	1.32	1.30	1.29	1.27	1.00	0.90
80 - 84	1.72	1.42	1.36	1.33	1.32	1.30	1.00	0.90
85+	1.77	1.45	1.38	1.36	1.34	1.32	1.00	0.90

**Table XXXVI(B).19 – Base Monthly Premium Rates per \$1,000 Benefit Amount
for Dependent Child Coverage**

Dependent Child Definition	Monthly Premium Rate per \$1,000 – From the 15 th Day of Life	Monthly Premium Rate per \$1,000 – From Birth
To age 18	0.106	0.126
To age 19	0.107	0.128
To age 20	0.108	0.129
To age 21	0.109	0.131
To age 22	0.110	0.132
To age 23	0.111	0.134
To age 24	0.112	0.135
To age 25	0.112	0.135
To age 26	0.113	0.137

METROPOLITAN LIFE INSURANCE COMPANY
Rate Manual – Section XXXVI(B)
Group Critical Illness Insurance
GCERT10-CI and GCERT10-CI-MOT

Table XXXVI(B).20 – Annual Trend

Time Period	Annual Trend Factor
7/1/2007+	1.005

Table XXXVI(B).21 – Commissions

The commission agreed upon by MetLife & the policyholder, and based on premium received and earned for the policy period:	Percentage of Premium
Minimum	0%
Standard	8%
Maximum	15%

Table XXXVI(B).22 – Modal Premium Factors

To Convert to:	Multiply By:
Quarterly	2.985
Semi-Annual	5.956
Annual	11.823

SERFF Tracking Number: META-126840677 State: Arkansas
 Filing Company: Metropolitan Life Insurance Company State Tracking Number: 46939
 Company Tracking Number: NY10-13 KC (LW)
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness
 Limited Benefit
 Product Name: Group Accident and Health Insurance
 Project Name/Number: GCERT10-CI series/NY10-13 KC

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Attached are the required compliance certifications.</p> <p>Attachments: ARCERTREAD.pdf ARCERTREG19.pdf</p>	Approved-Closed	10/08/2010

	Item Status:	Status Date:
<p>Bypassed - Item: Application</p> <p>Bypass Reason: Not Applicable to this filing submission.</p> <p>Comments:</p>	Approved-Closed	10/08/2010

	Item Status:	Status Date:
<p>Satisfied - Item: NAIC Transmittal Document</p> <p>Comments: Attached is the Transmittal Document.</p> <p>Attachment: L-A&H NAIC Transmittal Document 1-1-2009 [JBD].pdf</p>	Approved-Closed	10/08/2010



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
GCERT10-CI	Certificate form series	51.78
GCERT10-CI-MOT	Certificate rider	51.89
GEF10-CI	Enrollment Form	51.40

Michael F. Tietz
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 "Michael F. Tietz".

Michael F. Tietz
Vice President

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas
-----------	----------------------------------	----------

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	Metropolitan Life Ins. Co. 1095 6 th Ave, MSC 39042 New York, NY 10036	NY	Life & Health	241	65978	13-5581829	

4.	Contact Name & Address	Telephone #	Fax #	E-mail Address
	John David Metropolitan Life Ins. Co. 1095 6 th Ave, MSC 39042 New York, NY 10036	212-578-5954	212-578-3874	j david1@metlife.com

5.	Requested Filing Mode	<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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6.	Company Tracking Number	NY10-13 KC
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7.	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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8.	Market	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise <input type="checkbox"/> Small <input checked="" type="checkbox"/> Large <input type="checkbox"/> Small and Large <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input type="checkbox"/> Discretionary <input checked="" type="checkbox"/> Trust <input checked="" type="checkbox"/> Other: _____ Union
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9.	Type of Insurance (TOI)	H07G Group Health – Specified Disease – Limited Benefit
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10.	Sub-Type of Insurance (Sub-TOI)	H07G.001 Critical Illness
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11.	Submitted Documents	<input checked="" type="checkbox"/> FORMS <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input checked="" type="checkbox"/> Certificate <input checked="" type="checkbox"/> Application/Enrollment <input checked="" type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other Rates <input checked="" type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate <input type="checkbox"/> FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION <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 type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other _____
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12.	Filing Submission Date	September 30, 2010	
13	Filing Fee (If required)	Amount <u>\$150.00</u>	Check Date _____
		Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Check Number _____
14.	Date of Domiciliary Approval	n/a	

15.	Filing Description:		
<p>Please see our transmittal letter for details concerning this filing.</p>			

16.	Certification (If required)		
<p>I HEREBY CERTIFY 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>John B. David</u>		Title <u>Manager</u>	
Signature 		Date: <u>September 30, 2010</u>	

17.	Form Filing Attachment	
This filing transmittal is part of company tracking number		NY10-13 KC
This filing corresponds to rate filing company tracking number		

	Document Name	Form Number		Replaced Form Number
	Description			Previous State Filing Number
01	Face Page	GCERT10-CI-fp	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
02	Notice Page	GCERT10-CI-notice	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
03	Table of Contents	GCERT10-CI-toc	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
04	Schedule page	GCERT10-CI-sched	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
05	Definitions section	GCERT10-CI-def	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
06	Employee eligibility	GCERT10-CI-elig-ee	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
07	Dependent eligibility	GCERT10-CI-elig-dep	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
08	Benefit Provisions	GCERT10-CI-bene	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
09	Evaluation Benefit	GCERT10-CI-bene-eb	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
10	NCI Evaluation Benefit	GCERT10-CI-bene-nci	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
11	Waiver of premium	GCERT10-CI-wopr	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
12	Specific exclusions/proof requirements	GCERT10-CI-excl/proof	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			

13	General limitations	GCERT10-CI-limit	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
14	Waiting Period	GCERT10-CI-wp	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
15	Preexisting conditions exclusion	GCERT10-CI-prex	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
16	General exclusions	GCERT10-CI-exclu	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
17	Termination of coverage provisions	GCERT10-CI-term	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
18	Discontinuation and replacement	GCERT10-CI-dr2ml	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
19	Portability	GCERT10-CI-port	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
20	Continuation of coverage	GCERT10-CI-coi-eport	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
21	Claims provisions	GCEERT10-CI-claim	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
22	General Provisions	GCERT10-CI-gen pro	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
23	Group Enrollment Form	GEF10-CI	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Insert Form			
24	Major Organ Transplant Rider	GEF10-CI-MOT	<input checked="" type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	
	Certificate Rider			
			<input type="checkbox"/> Initial <input type="checkbox"/> Revised <input type="checkbox"/> Other _____	

LH FFA-1

18.		Rate Filing Attachment		
This filing transmittal is part of company tracking number		NY10-13 KC		
This filing corresponds to form filing company tracking number				
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing		%		
	Document Name	Affected Form Numbers		Previous State Filing Number
	Description			
01	Rate Manual Pages	GCERT10-CI certificate series	<input checked="" type="checkbox"/> New <input type="checkbox"/> Revised Request +____% -____% <input type="checkbox"/> Other _____	
02	Actuarial Memorandum	GCERT10-CI certificate series	<input checked="" 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