

SERFF Tracking Number: METD-126534010 State: Arkansas
 Filing Company: MetLife Insurance Company of Connecticut State Tracking Number: 45859
 Company Tracking Number: EMASBR-62-10 - MICC
 TOI: L06I Individual Life - Variable Sub-TOI: L06I.002 Single Life - Flexible Premium
 Product Name: SBR Application for Life Insurance
 Project Name/Number: SBR Applications /EMASBR-62-10

Filing at a Glance

Company: MetLife Insurance Company of Connecticut

Product Name: SBR Application for Life Insurance SERFF Tr Num: METD-126534010 State: Arkansas

TOI: L06I Individual Life - Variable SERFF Status: Closed-Approved- Closed State Tr Num: 45859

Sub-TOI: L06I.002 Single Life - Flexible Premium Co Tr Num: EMASBR-62-10 - MICC State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird
 Authors: Patricia Crowley, Karen Poor Disposition Date: 06/14/2010

Date Submitted: 06/03/2010 Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:
 State Filing Description:

General Information

Project Name: SBR Applications
 Project Number: EMASBR-62-10
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 06/14/2010

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Explanation for Other Group Market Type:
 State Status Changed: 06/14/2010
 Created By: Patricia Crowley
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Tricia St. John
 Filing Description:
 RE: Metropolitan Life Insurance Company
 NAIC # 241-65978 FEIN # 13-5581829

MetLife Insurance Company of Connecticut
 NAIC # 241-87726 FEIN # 06-0566090

SERFF Tracking Number: METD-126534010 State: Arkansas
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Individual Life Application Filing

Forms: EMASBR-62-10 Master Application for Life Insurance
ENBSBR-63-10 Application for Life Insurance
EMEDSBR-64-10 Part II: Underwriting Supplement
CFND-4-10 Variable Life Supplement
MFNDSBR-4-10 Variable Life Supplement

Enclosed are the above referenced forms that are being filed on behalf of the above companies.

The above application forms are enclosed for your review and approval. These are new forms that will not replace existing forms. These forms will be implemented once the computer data collection system for these forms is available. The forms are in final print and for actual field use, subject only to minor modifications in paper size, stock, ink, border, company logo and adaptation to computer printing. These application forms are being submitted as duplex forms. However, they may appear in the policy single-sided especially if they are faxed to us.

Where applicable, we have bracketed as variable information the company names on the multi-company forms. This will allow us to remove a company that ceases to sell new business without refilling them. We assure you that the only variability to the list of companies is the ability to remove a company name; no new insurer will be added to the application without refilling the application for all companies.

All of these forms will always be attached to a policy and would never be stand alone forms nor would they be given to the applicant unless attached to a policy. According to state regulations the policy cover page must include the company name and address. Since all of these forms will always be attached to a policy, we feel that we are still in compliance with state regulations with only listing the company names on these forms.

The following three forms are multi-company forms where we have listed the all of the company names that will use these forms. We have included instructions where the agent will check off the appropriate company name. These identical forms are being filed separately for each applicable company.

1. Master Application for Life Insurance, form EMASBR-62-10, will be used when applying for life insurance in the corporate owned life insurance market. It can be used to apply for insurance on multiple insureds using an Appendix to gather the required information on each insured. We have bracketed the following references in order to provide flexibility in updating these areas without refilling: the reference to Federal law and special needs clients in Section III; the riders/benefits in Section IV; the timeframes in the Actively at Work Information section; the fraud warnings under the Fraud Warnings section as states add or revise fraud warning requirements; and the definition of Guaranteed Issue Non-Smoker at the bottom of Schedule A.

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2. Application for Life Insurance, form ENBSBR-63-10, will be used when applying for life insurance. We have bracketed the following references in order to provide flexibility in updating these areas without refiling: the reference to Federal law and special needs clients in Section III; the riders/benefits in Section IV; the timeframes in the General Risk Questions section; and the fraud warnings under the Fraud Warnings section as states add or revise fraud warning requirements.

3. Part II - Underwriting Supplement, form EMEDSBR-64-10, will be used when medical underwriting is needed. This supplemental form will always be used in conjunction with an approved application for life insurance. We have bracketed the timeframes in certain questions in order to provide flexibility in updating these areas without refiling.

The following form is only available for Metropolitan Life Insurance Company:

- Variable Life Supplement, form MFNDSBR-4-10 is a supplement that contains fund selections. This supplement will always be used in conjunction with an approved life application. We have bracketed the funds to provide flexibility in updating the list of funds without refiling. Since this form will be used with a security subject to federal jurisdiction, it is exempt from readability requirements.

The following form is only available for MetLife Insurance Company of Connecticut:

- Variable Life Supplement, form CFND-4-10 is a supplement that contains fund selections. This supplement will always be used in conjunction with an approved life application. We have bracketed the funds to provide flexibility in updating the list of funds without refiling. Since this form will be used with a security subject to federal jurisdiction, it is exempt from readability requirements.

If you have any questions or need further information, please contact me at the number or e-mail address below.

Sincerely,

Karen L. Poor

Enclosures: Readability Certificate; Certification

Company and Contact

Filing Contact Information

Karen Poor, Senior Contract Consultant KPoor@metlife.com
501 Boylston Street 617-578-4730 [Phone]
Boston, MA 02116 617-578-5505 [FAX]

Filing Company Information

MetLife Insurance Company of Connecticut CoCode: 87726 State of Domicile: Connecticut

SERFF Tracking Number: METD-126534010 State: Arkansas
 Filing Company: MetLife Insurance Company of Connecticut State Tracking Number: 45859
 Company Tracking Number: EMASBR-62-10 - MICC
 TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
 Product Name: SBR Application for Life Insurance
 Project Name/Number: SBR Applications /EMASBR-62-10
 1300 Hall Boulevard Group Code: 241 Company Type: Life
 Bloomfield, CT 06002 Group Name: MetLife Group State ID Number:
 (617) 578-2000 ext. [Phone] FEIN Number: 06-0566090

Filing Fees

Fee Required? Yes
 Fee Amount: \$80.00
 Retaliatory? No
 Fee Explanation: Since CT does not have a fee, we are sending \$20 for each form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
MetLife Insurance Company of Connecticut	\$80.00	06/03/2010	36967565
MetLife Insurance Company of Connecticut	\$120.00	06/03/2010	36983388

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/14/2010	06/14/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	06/03/2010	06/03/2010	Tricia St. John	06/03/2010	06/03/2010

SERFF Tracking Number: *METD-126534010* *State:* *Arkansas*
Filing Company: *MetLife Insurance Company of Connecticut* *State Tracking Number:* *45859*
Company Tracking Number: *EMASBR-62-10 - MICC*
TOI: *L061 Individual Life - Variable* *Sub-TOI:* *L061.002 Single Life - Flexible Premium*
Product Name: *SBR Application for Life Insurance*
Project Name/Number: *SBR Applications /EMASBR-62-10*

Disposition

Disposition Date: 06/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Actuarial Memo		No
Supporting Document	Certification of Compliance		Yes
Form	Master Application for Life Insurance		Yes
Form	Application for Life Insurance		Yes
Form	Part II: Underwriting Supplement		Yes
Form	Variable Life Supplement		Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/03/2010
Submitted Date 06/03/2010
Respond By Date 07/05/2010

Dear Karen Poor,

This will acknowledge receipt of the captioned filing.

Objection 1

No Objections

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$120.00 is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Product Name: SBR Application for Life Insurance
Project Name/Number: SBR Applications /EMASBR-62-10

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/03/2010
Submitted Date 06/03/2010

Dear Linda Bird,

Comments:

Response 1

Comments: I apologize for the error in filing fee calculation. I have submitted an additional \$120 via EFT as you requested. Thank you.

Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the additional \$120.00 is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Karen Poor, Patricia Crowley

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	EMASBR-62-10	Application/Master Application Enrollment for Life Insurance Form	Initial		51.200	EMASBR-62-10 FINAL FOR PRINT.pdf
	ENBSBR-63-10	Application/ Application for Life Enrollment Insurance Form	Initial		57.700	ENBSBR-63-10 FINAL WORD.pdf
	EMEDSBR-64-10	Application/Part II: Underwriting Enrollment Supplement Form	Initial		60.100	EMEDSBR-64-10 FINAL WORD.pdf
	CFND-4-10	Application/Variable Life Enrollment Supplement Form	Initial		0.000	CFND-4-10 FINAL WORD.pdf



Master Application For Life Insurance

Company (Check the appropriate ONE)

The Company indicated in this section is referred to as **"the Company"**.

<input type="checkbox"/>	Metropolitan Life Insurance Company
<input type="checkbox"/>	MetLife Insurance Company of Connecticut

SECTION I – Corporation Information

Name of Corporation _____	Corporation Tax ID # _____
Address of Corporation _____	City _____ State _____ Zip _____

SECTION II– Owner Information

OWNER: Check here if same as Corporation.

For Owners who are **NOT** the Corporation, please complete below.

Name of Owner _____	Owner Tax ID # _____
Address of Owner _____	City _____ State _____ Zip _____

If Trust Owner, complete Trust Certification Form.

SECTION III – Beneficiary / Beneficiaries Information

Federal law states that if someone with special needs has assets over \$2,000 they may lose eligibility for government benefits.

BENEFICIARY: Check here if the Owner is the Primary Beneficiary.

For Primary Beneficiaries who are **NOT** the Owner, please complete below.

Primary: Name _____

SECTION IV – Proposed Coverage Information

Metropolitan Life Insurance Company:

Variable Universal Life Policy:

Product Name: _____

<input type="checkbox"/>	Term Rider
<input type="checkbox"/>	Interim Term Insurance Benefit (ITB)
<input type="checkbox"/>	Enhanced Cash Surrender Value Rider (ECSV)
<input type="checkbox"/>	Other _____

Universal Life Policy

Product Name: _____

<input type="checkbox"/>	Interim Term Insurance Benefit (ITB)
<input type="checkbox"/>	Other _____

MetLife Insurance Company of Connecticut:

Variable Universal Life Policy:

Product Name: _____

<input type="checkbox"/>	Term Rider
<input type="checkbox"/>	Cash Value Enhancement
<input type="checkbox"/>	Other _____

Premium Payment Mode: Single Annual If other please specify: _____

In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance?

Yes No

 If **YES**, complete **Replacement Questionnaire** AND any other state required replacement forms or 1035 exchange forms.

SECTION V– Special Instructions

If more space is needed, attach additional sheet(s).

SECTION VI – Actively At Work Information

As of the date you sign the application, have the Proposed Insured(s) listed on the attached Schedule A:

a. been currently engaged in active work on a full-time basis performing all duties of their regular occupation at their customary place of employment? A person will be deemed to be actively at work during weekends or corporation approved vacations, holidays or business closures if such person was actively at work on the last scheduled workday preceding such time off.

Yes No

If **NO**, please explain. _____

b. during the [90] days immediately prior to the date of this application, been hospitalized or otherwise absent from work (for example, due to illness, accident or medical treatment but excluding vacations, holidays or other business closures) for more than [five] consecutive days?

Yes No

If **YES**, please explain. _____

Additional Information:

Agreement / Disclosure

I, the Owner, have read this application for life insurance, including the attached Schedule A, including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application, including the attached Schedule A, and any amendment(s) and supplement(s) are the basis of any policy issued.
- This application, including the attached Schedule A, and any amendment(s) and supplement(s) to this application will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application, including the attached Schedule A and supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract or insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No insurance will take effect until the required documentation and the full first premium due is paid.
- I understand that paying my insurance premiums more frequently than annually may result in different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**
- All or part of the information, records and data that the Company receives may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.

Fraud Warnings

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma

Any person who knowingly and with intent to defraud any insurance company or any 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.

District of Columbia, Tennessee, Virginia, Washington

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

Owner Representations

(For Corporate, Trust and other Owners)

The Owner hereby represents to the Company that based upon applicable law, it has sufficient insurable interest in the lives of the Proposed Insured(s) to support issuance of the life insurance Policy(ies) applied for. The Owner further represents that it has sought legal counsel with respect to the facts and issues surrounding such issuance. The Owner has obtained the written consent of each Proposed Insured and has complied with all applicable laws. The Owner acknowledges that the Company is issuing the life insurance Policy(ies) applied for in reliance on these representations

Signatures

Print Name of Authorized Signatory of Corporation Trust

Signature of Authorized Signatory of Corporation Trust

Date

Signed at City, State



Title

Print Name of Witness

Witness Signature

Date



Application For Life Insurance

Company (Check the appropriate ONE)

The Company indicated in this section is referred to as "the Company".

<input type="checkbox"/> Metropolitan Life Insurance Company
<input type="checkbox"/> MetLife Insurance Company of Connecticut

SECTION I – Proposed Insured Information

First Name _____ Middle Name _____ Last Name _____

Permanent Address _____ City _____ State _____ Zip _____

Country of Legal Residence _____ Earned Annual Income _____ Net Worth _____

Date of Birth _____ Place of Birth _____ Social Security Number _____ Sex Male
 Female

U.S. Driver's License Issuer of ID (State, Country) _____ If not licensed, please indicate other form of ID: Passport Issue Date (if any) _____ Government Issued Photo ID Expiration Date (if any) _____

NON U.S. CITIZENS ONLY - Country of Citizenship _____	Green Card/Visa Type _____	Expiration Date _____
Country of Permanent Residence _____	ID Number _____	Years in the U.S. _____

Name of Employer _____

Address of Employer _____ City _____ State _____ Zip _____

Work Address (if different than Address of Employer) _____ City _____ State _____ Zip _____

Title/Duties _____

SECTION II – Owner Information

 Complete **ONLY** if the Owner is **NOT** the Proposed Insured.

OWNER - TRUST / BUSINESS ENTITY - Name of Entity _____ Tax ID Number _____ Trustee / Owner State _____

If Trust Owned complete Trust Certification Form.

OWNER – OTHER INDIVIDUAL

First Name _____ Middle Name _____ Last Name _____

Address of Owner _____ City _____ State _____ Zip _____

Country of Legal Residence _____ Earned Annual Income _____ Net Worth _____ Relationship to Proposed Insured _____ Owner SSN or Tax ID _____

Please indicate form of ID: U.S. Driver's License Issuer of ID (State, Country) _____ ID Number _____ Passport Issue Date (if any) _____ Government Issued Photo ID Expiration Date (if any) _____

SECTION III – Beneficiary / Beneficiaries Information

Check here if the Owner is the Primary Beneficiary.

For Primary or Contingent Beneficiaries who are NOT the Owner, complete the table below.

Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured	Social Security Number (Optional)	Percentage of Proceeds (if not equal)
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary					
<input type="checkbox"/> Contingent					
<input type="checkbox"/> Contingent					
<input type="checkbox"/> Contingent					

Is the Beneficiary designation irrevocable? Yes No

Federal law states that if someone with special needs has assets over \$2,000 they may lose eligibility for government benefits.

SECTION IV – Proposed Coverage Information

Metropolitan Life Insurance Company:

Variable Universal Life Policy:

Product Name: _____

Total Face Amount: \$ _____

Base Face Amount: \$ _____

Term Rider _____ Term Ratio: _____
 Face Amount: \$ _____

Interim Term Insurance Benefit (ITB)

Enhanced Cash Surrender Value Rider (ECSV)

Other _____

Universal Life Policy

Product Name: _____

Total Face Amount: \$ _____

Interim Term Insurance Benefit (ITB)

Other _____

MetLife Insurance Company of Connecticut:

Variable Universal Life Policy:

Product Name: _____

Total Face Amount: \$ _____

Base Face Amount: \$ _____

Term Rider _____ Term Ratio: _____
 Face Amount: \$ _____

Cash Value Enhancement

Other _____

Initial Premium \$ _____ Planned Premium \$ _____

Premium Payment Mode: Single Annual If other please specify: _____

Death Benefit Option: _____ Definition of Life Insurance: Guideline Premium Test Cash Value Accumulation Test

SECTION V – Special Instructions

If more space is needed, attach additional sheet(s).

SECTION VI – Payment Information**PREMIUM PAYOR**
 Proposed Insured
 Owner (If NOT the Proposed Insured.)
 Other (Complete the box below.)

Other Premium Payor Name	Social Security or Tax ID Number	Relationship to Proposed Insured or Owner	
Reason this Person/Entity is the Payor			
Permanent Address	City	State	Zip

SOURCE OF CURRENT AND FUTURE PAYMENTS (Check **ALL** that apply.)
 Corporate Assets
 Mutual Fund/Brokerage Account
 Savings
 Earned Income
 Money Market Fund
 Loans
 Certificate of Deposit
 Use of Values in another Life Insurance/Annuity Contract
 Other _____
SECTION VII – Existing or Applied for Insurance

Does the Proposed Insured or Owner have any existing or applied for life insurance or annuities with this or any other company?

Proposed Insured Yes No
 Owner Yes No

If **YES**, please provide details of any existing or applied for **Life** Insurance on the **Proposed Insured only**.

Company	Amount of Insurance	Year of Issue	Status	
			<input type="checkbox"/> Existing	<input type="checkbox"/> Applied For
			<input type="checkbox"/> Existing	<input type="checkbox"/> Applied For
			<input type="checkbox"/> Existing	<input type="checkbox"/> Applied For
			<input type="checkbox"/> Existing	<input type="checkbox"/> Applied For
			<input type="checkbox"/> Existing	<input type="checkbox"/> Applied For

In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? Yes No

 If **YES**, complete **Replacement Questionnaire** AND any other state required replacement forms or 1035 exchange forms.

SECTION VIII – General Risk Questions

Has the Proposed Insured smoked/used cigarettes or nicotine substitutes (e.g. nicotine gum, nicotine patches, etc.) within the last [12 months] of this application? If **YES**, please provide details.

Yes No

Product(s)	Frequency/Amount	Date Last Used

As of the date you sign the application, has the Proposed Insured:

a. been currently engaged in active work on a full-time basis performing all duties of his/her regular occupation at his/her customary place of employment? A person will be deemed to be actively at work during weekends or policyholder approved vacations, holidays or business closures if such person was actively at work on the last scheduled workday preceding such time off.

Yes No

If **NO**, please explain.

b. during the [90] days immediately prior to the date of this Application, been hospitalized or otherwise absent from work (for example, due to illness, accident or medical treatment but excluding vacations, holidays or other business closures) for more than [five] consecutive days?

Yes No

If **YES**, please explain.

Additional Information: If more space is needed, attach additional sheet(s).

Agreement / Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application, paramedical/medical exam, and supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract or insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- No insurance will take effect until the required documentation is received by the Company and the full first premium due is paid.
- I understand that paying my insurance premiums more frequently than annually may result in different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**
- **If I was required to sign a Notice of Consent for HIV Testing, I have received a copy of that Notice.**
- All or part of the information, records and data that the Company receives may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.

Fraud Warnings

Arkansas, Kentucky, Louisiana, New Mexico, Ohio, Oklahoma

Any person who knowingly and with intent to defraud any insurance company or any 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.

District of Columbia, Tennessee, Virginia, Washington

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

Owner Representations

(For Corporate, Trust and other Owners who are not the Proposed Insured)

The Owner hereby represents to the Company that based upon applicable law, it has sufficient insurable interest in the life of the Proposed Insured to support issuance of the life insurance Policy applied for. The Owner further represents that it has sought legal counsel with respect to the facts and issues surrounding such issuance. The Owner acknowledges that the Company is issuing the life insurance Policy(ies) applied for in reliance on these representation

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

- The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
 - (a) I have not been notified by the IRS that I am subject to backup withholdings as a result of a failure to report all interest or dividends; **or**
 - (b) The IRS has notified me that I am not subject to backup withholding.
(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)
- I am a U.S. citizen or a U.S. resident alien for tax purposes.
(If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

❗ **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Signatures

Signature of Proposed Insured

Date

Signed at City, State



Print Name of Owner if not Proposed Insured

Signature of Owner if not Proposed Insured

Date

Signed at City, State



Print Name of Witness

Witness Signature

Date



Part II – Underwriting Supplement

Company (Check the appropriate ONE)

The Company indicated in this section is referred to as “the Company”.

<input type="checkbox"/> Metropolitan Life Insurance Company
<input type="checkbox"/> MetLife Insurance Company of Connecticut

This supplement will be attached to and become part of the application with which it is used.

SECTION I – Proposed Insured Information

First Name		Middle Name		Last Name			
Home Phone Number	Work Phone Number	Cell Phone Number	Preferred Time to Call	From	<input type="checkbox"/> AM <input type="checkbox"/> PM	To	<input type="checkbox"/> AM <input type="checkbox"/> PM
			Best number to call: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell				

SECTION II – General Risk Questions

- Within the past [three] years has the Proposed Insured flown in a plane other than as a passenger on a commercial airline or does he or she have plans for such activity within the next [year]? Yes No

If **YES**, please complete a separate **Aviation Risk Supplement** form for the Proposed Insured.
- Within the past [three] years has the Proposed Insured participated in or does he or she plan to participate in **any** of the following? Yes No

 - Underwater sports – SCUBA diving, skin diving, or similar activities
 - Racing sports – motorcycle, auto, motor boat or similar activities
 - Sky sports – skydiving, hang gliding, parachuting, ballooning or similar activities
 - Rock or mountain climbing or similar activities
 - Bungee jumping or similar activities

If **YES**, please complete a separate **Avocation Risk Supplement** form for the Proposed Insured.
- Has the Proposed Insured **traveled** or **resided** outside the U.S. or Canada within the **past [two] years**; or does he or she plan to **travel** or **reside** outside the U.S or Canada within the **next [two] years**? If **YES**, please provide details. Yes No

Past	Future	Duration (weeks)	Cities and Countries	Purpose
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>			

- Has the Proposed Insured **EVER** had a driver's license suspended or revoked, been convicted of DUI or DWI, or in the last five years had any moving violations? If **YES**, please provide date(s) and violation(s). Yes No

- Has the Proposed Insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? If **YES**, please provide details. Yes No

- In the past [10] years, has the Proposed Insured been convicted of or pled Guilty or No Contest to a felony? If **YES**, list type of felony, state, and date of occurrence. Yes No

- Is the Proposed Insured actively at work performing the usual duties of his or her occupation? If **NO**, please provide details. Yes No

8. Has the Proposed Insured ever smoked/used tobacco or nicotine products (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)? If **YES**, please provide details. Yes No

Product(s)	Frequency / Amount	Date Last Used

SECTION III – Personal Physician

Physician Name _____ Name of Practice or Clinic _____

Street Address _____ City _____ State _____ Zip _____

Phone Number _____ Date Last Consulted _____ Reason _____

Findings / Treatment Given / Medication Prescribed _____

SECTION IV – Medical Questions

1. Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____

Has the Proposed Insured experienced a change in weight greater than [10] pounds in the past [12] months? Yes No

If **YES**, please specify: Pounds Lost _____ Pounds Gained _____ Reason _____

2. Has the Proposed Insured **EVER** been diagnosed, received treatment, or consulted with a health professional for any of the following? If **YES**, please check **ALL** that apply and provide details in table below. Yes No

- | | | | |
|--|---|---|--|
| A. <input type="checkbox"/> High Blood Pressure | H. <input type="checkbox"/> Asthma / Bronchitis | O. <input type="checkbox"/> Parkinson's Disease | V. <input type="checkbox"/> Lupus |
| B. <input type="checkbox"/> Chest Pain | I. <input type="checkbox"/> Emphysema | P. <input type="checkbox"/> Alzheimer's Disease | W. <input type="checkbox"/> Anemia |
| C. <input type="checkbox"/> Heart Attack | J. <input type="checkbox"/> Sleep Apnea | Q. <input type="checkbox"/> Memory Loss | X. <input type="checkbox"/> Depression / Anxiety |
| D. <input type="checkbox"/> Heart Murmur | K. <input type="checkbox"/> Seizures | R. <input type="checkbox"/> Colitis | Y. <input type="checkbox"/> Eating Disorder |
| E. <input type="checkbox"/> Diabetes | L. <input type="checkbox"/> Stroke / TIA | S. <input type="checkbox"/> Cirrhosis | |
| F. <input type="checkbox"/> High Cholesterol | M. <input type="checkbox"/> Paralysis | T. <input type="checkbox"/> Hepatitis | |
| G. <input type="checkbox"/> Cancer / Tumor / Polyp | N. <input type="checkbox"/> Multiple Sclerosis | U. <input type="checkbox"/> Arthritis | |

Letter	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

3. Other than as indicated above, has the Proposed Insured **EVER** had any disease or disorder of any of the following? If **YES**, please check **ALL** that apply and provide details in table below. Yes No

- | | | |
|---|--|--|
| A. <input type="checkbox"/> Heart | G. <input type="checkbox"/> Prostate | M. <input type="checkbox"/> Thyroid / Other Glands |
| B. <input type="checkbox"/> Arteries / Veins | H. <input type="checkbox"/> Reproductive Organs | N. <input type="checkbox"/> Eyes |
| C. <input type="checkbox"/> Lungs / Respiratory System | I. <input type="checkbox"/> Brain / Nervous System | O. <input type="checkbox"/> Ears / Nose / Throat |
| D. <input type="checkbox"/> Gastrointestinal / Digestive System | J. <input type="checkbox"/> Blood | P. <input type="checkbox"/> Skin |
| E. <input type="checkbox"/> Liver / Pancreas | K. <input type="checkbox"/> Lymph Nodes | Q. <input type="checkbox"/> Muscles / Bones / Joints |
| F. <input type="checkbox"/> Kidney / Bladder | L. <input type="checkbox"/> Immune System | R. <input type="checkbox"/> Emotional / Psychological Disorder |

Letter	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

4. Other than as indicated previously, within the past [five] years, has the Proposed Insured had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility? Yes No
5. Is the Proposed Insured currently receiving any treatment or taking any prescription or nonprescription medications or supplements? Yes No
6. Does the Proposed Insured have any surgery, medical tests, treatment or visits with a health professional scheduled in the next [six] months? Yes No
7. Has the Proposed Insured ever been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? Yes No
8. Has the Proposed Insured ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus? Yes No
9. Has the Proposed Insured ever used cocaine, heroin, or other illicit drugs or controlled substance except as prescribed by a health professional? Yes No
10. Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health professional or support group? Yes No

If **YES**, please provide details in table below for Questions 4 - 10.

Number	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

SECTION V – Family History

Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer; or kidney disease? If **YES**, please provide details in table below. Yes No

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			

SECTION VI – Additional Information

If more space is needed, attach additional sheet(s).



Variable Life Supplement

MetLife Insurance Company of Connecticut

This supplement will be attached to and become part of the application with which it is used.

SECTION I – Important Information for the Owner

⚠ Please Read Carefully.

Variable Life Insurance is generally not appropriate for time horizons of less than 10 years. These are long-term insurance products that may have significant short-term surrender charges. Variable Life Insurance is designed to provide death benefit protection while offering the potential for long-term cash accumulation, and may not be appropriate in situations where significant liquidation of assets in the near future may be expected.

The cash value may increase or decrease, even to the extent of being reduced to zero, in accordance with separate account investment experience.

The cost of insurance rates for this policy may change. The rates currently being charged are not guaranteed, and the Company may charge the full maximum guaranteed rates.

Illustrations of benefits, including death benefits and cash values, are available upon request.

The death benefit may be variable or fixed under specified conditions.

SECTION II – Owner Information

OWNER: Proposed Insured Trust/Business Entity Other Individual

Name of **Proposed Insured** or **Trust/Business Entity**: _____

OTHER INDIVIDUAL INFORMATION ONLY:

First Name		Middle Name	Last Name
Occupation		Name of Employer	
Employer city	State	Zip	Position / Duties

Tax Bracket (%) _____ Is the Owner or a member of the Owner's household employed by or associated with a Broker-Dealer, other firm within the securities industry, or a financial regulatory agency? Yes No

Liquid Net Worth \$ _____ (Liquid Net Worth is assets that can be turned into cash quickly and easily. Include the amount of the initial premium and/or any lump sum payment for this coverage. Exclude your personal property, personal residence, real estate, business equity, home furnishings and autos.)

PRIOR INVESTMENT EXPERIENCE:

(Not Required when using the Master Application. Choose **ALL** that apply and indicate years of experience.)

Certificate of Deposit _____ years Stocks _____ years Mutual Funds _____ years Money Markets _____ years
 Bonds _____ years Other _____ years If Other, specify: _____

SECTION III – Investment Objective and Risk Tolerance

Have you completed the Asset Allocation Questionnaire? Yes No If **YES**, please submit with this Supplement. Choose one **Investment Objective** below (a, b, c, d, or e). Then choose one **Risk Tolerance** for that specific Investment Objective. Be sure it supports the Investment Objective and your Risk Tolerance for this policy.

- a. **Capital Preservation:** Seeks income and stability with minimal risk.
Risk Tolerance: Conservative Conservative to Moderate
- b. **Income:** Seeks current income over time.
Risk Tolerance: Conservative Conservative to Moderate Moderate
- c. **Growth & Income:** Seeks capital appreciation over long term combined with current dividend income.
Risk Tolerance: Conservative to Moderate Moderate Moderate to Aggressive
- d. **Growth:** Seeks capital appreciation over long term.
Risk Tolerance: Moderate Moderate to Aggressive Aggressive
- e. **Aggressive Growth:** Seeks maximum capital appreciation over time by investing in speculative and/or higher securities.
Risk Tolerance: Moderate to Aggressive Aggressive

SECTION IV – Investment Allocation

Please select funding options that are appropriate for the RISK TOLERANCE and INVESTMENT OBJECTIVE indicated in Section III - Investment Objective and Risk Tolerance. Some funding options may be appropriate for more than one investment objective. For more complete information about a specific funding option, including charges and expenses, please read the prospectus carefully.

Indicate Initial Allocation in whole percentages; must equal 100%.		COLI 1	COLI 2000	COLI III	COLI IV	COLI Select
Fixed Account	FF					
AIM Invesco Global Real Estate Fund – Series I	BP					
AIM Invesco International Growth – Series I	AH					
AIM Invesco Van Kampen V.I. Comstock Portfolio – Series II	BO					
AIM Invesco Van Kampen V.I. Government Fund – Series I	CQ					
AllianceBernstein VP Series Fund- Intermediate Bond Portfolio - Class A	BS					
AllianceBernstein VP Series Fund- International Value Portfolio - Class A	6A					
AllianceBernstein VP Series Fund- Global Thematic Growth Portfolio - Class B	BQ					
American Century VP Ultra® Fund - Class I	AA					
American Century VP Vista SM Fund - Class I	BT					
American Funds Bond Fund - Class 2	BV					
American Funds Global Growth Fund - Class 2	IL					
American Funds Global Small Capitalization Fund - Class 2	BW					
American Funds Growth Fund - Class 2	IG					
American Funds Growth-Income Fund - Class 2	II					
American Funds High-Income Bond Fund - Class 2	BX					
American Funds International Fund - Class 2	BY					
American Funds New World Fund - Class 2	BZ					
American Funds U.S. Government/AAA Rated Securities Fund - Class 2	B1					
Delaware VIP Small Cap Value Series - Standard Class	VA					
Dreyfus VIF Appreciation Portfolio - Initial Shares	DP					
Dreyfus VIF Opportunistic Small Cap Portfolio - Initial Shares	DS					
Dreyfus VIF International Value Portfolio - Initial Shares	6B					
Fidelity VIP Contrafund® Portfolio - Service Class 2	FT					
Fidelity VIP Contrafund® Portfolio - Initial Class	FG					
Fidelity VIP Equity-Income Portfolio - Initial Class	B2					
Fidelity VIP Freedom 2010 Portfolio - Initial Class	B3					
Fidelity VIP Freedom 2015 Portfolio - Initial Class	B4					
Fidelity VIP Freedom 2020 Portfolio - Initial Class	B5					
Fidelity VIP Freedom 2025 Portfolio - Initial Class	B6					
Fidelity VIP Freedom 2030 Portfolio - Initial Class	B7					
Fidelity VIP Growth & Income Portfolio - Service Class 2	A1					
Fidelity VIP High Income Portfolio - Initial Class	BG					
Fidelity VIP Index 500 Portfolio - Initial Class	BH					
Fidelity VIP Investment Grade Bond Portfolio - Service Class	B8					
Fidelity VIP Mid Cap Portfolio - Service Class 2	FM					

May not be available in all cases Funds not available

Please select funding options that are appropriate for the RISK TOLERANCE and INVESTMENT OBJECTIVE indicated in Section III - Investment Objective and Risk Tolerance. Some funding options may be appropriate for more than one investment objective. For more complete information about a specific funding option, including charges and expenses, please read the prospectus carefully.

Indicate Initial Allocation in whole percentages; must equal 100%.		COLI 1	COLI 2000	COLI III	COLI IV	COLI Select
Fidelity VIP Overseas Portfolio - Service Class 2	VN					
Franklin Templeton VIP Templeton Developing Markets Securities Fund - Class 2	VQ					
Franklin Templeton VIP Templeton Foreign Securities Fund - Class 2	TI					
Franklin Templeton VIP Templeton Global Bond Securities Fund - Class 1	VL					
Franklin Templeton VIP Mutual Global Discovery Securities Fund - Class 2	6C					
Franklin Templeton VIP Franklin Small-Mid Cap Growth Securities Fund - Class 2 ⁽³⁾	UW					
Janus Aspen Series Enterprise Portfolio - Service Shares	BL					
Janus Aspen Series Global Technology Portfolio - Service Shares	GP					
Janus Aspen Series Janus Aspen Perkins Mid Cap Value Portfolio - Service Shares	BM					
Janus Aspen Series Overseas Portfolio - Service Shares	BK					
Janus Aspen Series Worldwide Portfolio - Service Shares ⁽²⁾	WW					
Legg Mason ClearBridge Variable Aggressive Growth Portfolio - Class I	SG					
Legg Mason ClearBridge Variable Appreciation Portfolio - Class I	BA					
Legg Mason ClearBridge Variable Equity Income Builder Portfolio - Class I	AE					
Legg Mason ClearBridge Variable Fundamental All Cap Value Portfolio - Class I	KR					
Legg Mason ClearBridge Variable Large Cap Value Portfolio - Class I	C2					
Legg Mason ClearBridge Variable Large Cap Growth Portfolio - Class I	AB					
Legg Mason Global Currents Variable International All Cap Opportunity Portfolio ⁽¹⁾	KI					
Legg Mason Investment Counsel Variable Social Awareness Portfolio	SA					
Legg Mason Western Asset Variable Global High Yield Bond Portfolio - Class I	CJ					
Legg Mason Western Asset Variable Strategic Bond Portfolio - Class I	CZ					
MFS® VIT MFS® Global Equity Series - Initial Class	6G					
MFS® VIT MFS® High Income Series - Initial Class	6H					
MFS® VIT MFS® New Discovery Series - Initial Class	6J					
MIST BlackRock High Yield Portfolio - Class A	UB					
MIST BlackRock Large Cap Core Portfolio - Class E	DR					
MIST Clarion Global Real Estate Portfolio - Class A	AQ					
MIST Harris Oakmark International Portfolio - Class A	1C					
MIST Janus Forty Portfolio - Class A	US					
MIST Lazard Mid Cap Portfolio - Class A	1M					
MIST Loomis Sayles Global Markets Portfolio - Class A	IN					
MIST Lord Abbett Bond Debenture Portfolio - Class A	AF					
MIST Lord Abbett Growth and Income Portfolio - Class B	AG					
MIST Lord Abbett Mid Cap Value Portfolio - Class B	FN					
MIST Invesco Small Cap Growth Portfolio - Class A ⁽⁴⁾	AW					

 May not be available in all cases  Funds not available

Please select funding options that are appropriate for the RISK TOLERANCE and INVESTMENT OBJECTIVE indicated in Section III - Investment Objective and Risk Tolerance. Some funding options may be appropriate for more than one investment objective. For more complete information about a specific funding option, including charges and expenses, please read the prospectus carefully.

Indicate Initial Allocation in whole percentages; must equal 100%.		COLI 1	COLI 2000	COLI III	COLI IV	COLI Select
MIST MFS® Emerging Markets Equity Portfolio - Class A ⁽⁴⁾	AU					
MIST MFS® Research International Portfolio - Class B ⁽²⁾	ON					
MIST PIMCO Inflation Protected Bond Portfolio - Class A	PR					
MIST Pioneer Fund Portfolio - Class A	UP					
MIST Pioneer Strategic Income Portfolio - Class A	KP					
MIST T. Rowe Price Mid Cap Growth Portfolio - Class A	CD					
MIST Third Avenue Small Cap Value Portfolio - Class B ⁽⁴⁾	OP					
MIST Morgan Stanley Mid Cap Growth Portfolio - Class A	CE					
MSF Artio International Stock Portfolio - Class A	CH					
MSF Barclays Capital Aggregate Bond Index Portfolio - Class A	CA					
MSF BlackRock Aggressive Growth Portfolio - Class D	MH					
MSF BlackRock Bond Income Portfolio - Class A	1L					
MSF BlackRock Diversified Portfolio - Series A	FT					
MSF BlackRock Large Cap Value Portfolio - Class B	CF					
MSF BlackRock Legacy Large Cap Growth Portfolio - Class A	BB					
MSF BlackRock Money Market Portfolio - Class A	1K					
MSF Davis Venture Value Portfolio - Class A	CG					
MSF FI Value Leaders Portfolio - Class D	1F					
MSF Jennison Growth Portfolio - Class A	CS					
MSF MetLife Aggressive Allocation Portfolio - Class B	AK					
MSF MetLife Conservative Allocation Portfolio - Class B	AL					
MSF MetLife Conservative to Moderate Allocation Portfolio - Class B	AO					
MSF MetLife Mid Cap Stock Index Portfolio - Class A	CM					
MSF MetLife Moderate Allocation Portfolio - Class B	AM					
MSF MetLife Moderate to Aggressive Allocation Portfolio - Class B	AV					
MSF MetLife Stock Index Portfolio - Class A	SI					
MSF MFS® Total Return Portfolio - Class F	CT					
MSF MFS® Value Portfolio - Class A	BD					
MSF Morgan Stanley EAFE® Index Portfolio - Class A	CN					
MSF Oppenheimer Global Equity Portfolio - Class B	VM					
MSF Russell 2000® Index Portfolio - Class A	TJ					
MSF T. Rowe Price Large Cap Growth Portfolio - Class B ⁽³⁾	PF					
MSF Western Asset Management U.S. Government Portfolio - Class A	GV					
Oppenheimer VAF Main Street Small Cap Fund®/ VA - Non-Service Shares	CO					
PIMCO VIT Long-Term U.S. Government Portfolio - Administrative Class	AJ					
PIMCO VIT Low Duration Portfolio - Administrative Class	VO					

May not be available in all cases
 Funds not available

Please select funding options that are appropriate for the RISK TOLERANCE and INVESTMENT OBJECTIVE indicated in Section III - Investment Objective and Risk Tolerance. Some funding options may be appropriate for more than one investment objective. For more complete information about a specific funding option, including charges and expenses, please read the prospectus carefully.

Indicate Initial Allocation in whole percentages; must equal 100%.		COLI 1	COLI 2000	COLI III	COLI IV	COLI Select
PIMCO VIT Total Return Portfolio - Administrative Class	PM					
Pioneer Emerging Markets VCT Portfolio - Class II	BN					
Pioneer Mid Cap Value VCT Portfolio - Class II	PA					
Putnam VT International Value Fund - Class IB	CP					
Putnam VT New Opportunities Fund - Class IB ⁽¹⁾	OV					
Royce Capital Fund Micro-Cap Portfolio - Investment Class	AX					
Royce Capital Fund Small-Cap Portfolio - Investment Class	AY					
The UIF Emerging Markets Debt Portfolio - Class I	6K					
The UIF Emerging Markets Equity Portfolio - Class I	AZ					
Vanguard Variable Insurance Fund Diversified Value Portfolio	VB					
Vanguard Variable Insurance Fund Equity Index Portfolio	VE					
Vanguard Variable Insurance Fund Mid-Cap Index Portfolio	VP					
Vanguard Variable Insurance Fund Short-Term Investment Grade Portfolio	VH					
Vanguard Variable Insurance Fund Small Company Growth Portfolio	VI					
Vanguard Variable Insurance Fund Total Stock Market Index Portfolio	VJ					

- ⁽¹⁾ Closed to new sales effective May 1, 2003
- ⁽²⁾ Closed to new sales effective May 3, 2004
- ⁽³⁾ Closed to new sales effective May 2, 2005
- ⁽⁴⁾ Closed to new sales effective April 28, 2008

May not be available in all cases Funds not available

OTHER – Write in any available funds not listed above.

Funding Options: _____ Initial Premium Allocation (%) _____

SECTION V – Other Important Owner Questions

1. Have you received a prospectus for the policy applied for? Yes No

If **YES**, please indicate:

Date of Prospectus

Prospectus Book Number

Date of any Prospectus Supplement Package

2. Did your Producer review your financial situation, risk tolerance, and investment objectives prior to completing this application? Yes No

If **NO**, please indicate on what basis this product was recommended.

3. Do you understand that:

A. The amount and duration of the death benefit may increase or decrease depending on the policy's investment return, subject to any guarantees provided by the policy? Yes No

B. There is no guaranteed minimum cash value and the cash value may increase or decrease depending on the policy's investment return? Yes No

4. Do you believe that this policy and the funding options you have selected will meet your insurance needs and financial objectives? Yes No

5. If funding options selected do not reflect the risk tolerance in Section III – Investment Objective and Risk Tolerance, please explain: Yes No

SERFF Tracking Number: METD-126534010 State: Arkansas
Filing Company: MetLife Insurance Company of Connecticut State Tracking Number: 45859
Company Tracking Number: EMASBR-62-10 - MICC
TOI: L061 Individual Life - Variable Sub-TOI: L061.002 Single Life - Flexible Premium
Product Name: SBR Application for Life Insurance
Project Name/Number: SBR Applications /EMASBR-62-10

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR Readability Cert-MICC.pdf

Item Status: **Status**
Date:

Satisfied - Item: Certification of Compliance

Comments:

Attachment:

AR Certification-MICC.pdf

MetLife Insurance Company of Connecticut
1300 Hall Boulevard, Bloomfield, CT 06002

State of Arkansas

Readability Certification

Pursuant to Bulletin 14-79 and Arkansas Statute Annotated § 23-80-206 to § 23-80-208, cited as the Life and Disability Insurance Policy Language Simplification Act, the Flesch Readability Ease Test has been applied to the following forms.

Form Number(s)	Flesch Score(s)
EMASBR-62-10	51.2
ENBSBR-63-10	57.7
EMEDSBR-64-10	60.1



Karen Johnson, Assistant Vice President

6/1/2010

Date

MetLife Insurance Company of Connecticut
1300 Hall Boulevard, Bloomfield, CT 06002

State of Arkansas

Certification

We certify compliance with Rule and Reg. 19 s 10 and all other applicable requirements of the Arkansas Insurance Department.



Karen Johnson, Assistant Vice President

6/1/2010

Date