

State: Arkansas **Filing Company:** MetLife Investors USA Insurance Company
TOI/Sub-TOI: L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Product Name: Term 2012
Project Name/Number: 5E-23-12 CDT/5E-23-12

Filing at a Glance

Company: MetLife Investors USA Insurance Company
Product Name: Term 2012
State: Arkansas
TOI: L04I Individual Life - Term
Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium
Filing Type: Form
Date Submitted: 08/15/2012
SERFF Tr Num: METD-128617572
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: CDT 5E-23-12

Implementation: On Approval
Date Requested:
Author(s): Susan Patturelli, Diane Palermo, Dale Bihlmeyer
Reviewer(s): Linda Bird (primary)
Disposition Date: 08/21/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: 5E-23-12 CDT Status of Filing in Domicile: Pending
Project Number: 5E-23-12 Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type:
Overall Rate Impact: Filing Status Changed: 08/21/2012
State Status Changed: 08/21/2012
Deemer Date: Created By: Diane Palermo
Submitted By: Diane Palermo Corresponding Filing Tracking Number:

Filing Description:

RE: MetLife Investors USA Insurance Company
NAIC # 241-61050 FEIN # 54-0696644
Individual Life Filing
Forms: 5E-23-12-ARCTWVWY Term Life Insurance Policy
5E-E110-12 Endorsement
New Submission
State of Domicile: Delaware

The above-referenced forms are enclosed for your review and approval. These are new forms that will not replace any existing forms. The forms are final subject only to minor modifications in layout, paper size, color, stock, ink, border, font, company logo and adaptation to computer printing. Additionally, we reserve the right to correct minor typographical errors. Finally, "PAGE HAS BEEN INTENTIONALLY LEFT BLANK" will appear on each blank page of the Policy and riders when issued.

Policy Form 5E-23-12-ARCTWVWY is a non-participating renewable individual term life policy. There are four plans available on this policy (10, 15, 20 and 30-year term). Premiums are level for the initial term period and are guaranteed for the life of the policy. This policy has no cash value and is not subject to the NAIC illustration regulations.

This policy will be used for both unisex and sex-distinct issues. Unisex policies will be issued in employer-employee situations subject to the Norris decision or Title VII of the Civil Rights Act of 1964, or if required by state law. A provision is included in the policy that states if a policy is issued on a unisex basis, any reference to sex is deleted and all premiums and values will be on a unisex basis. We use an 80/20 Male/Female blend for unisex issues.

Endorsement Form 5E-E110-12 is a will preparation endorsement. It provides for the preparation of a simple or complex will as well as the creation of any testamentary trust as well as the preparation of codicils and will amendments for the Insured and the Insured's spouse.

Items have been bracketed in the enclosed forms to indicate that we will consider it acceptable to change these items in the future without re-filing the forms with your Department, unless you advise otherwise during your review of this form. The number of days in the free look provision has been bracketed so that we may update that number in accordance with the laws and regulations of your state based on how the policy was marketed or issued.

You have our assurance that we are in compliance with Ark. Code Ann. 23-79-138 and Regulation 49.

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We look forward to receiving your approval of these forms. Thank you for your attention to this filing.

Sincerely,

Susan Patturelli

Enclosures: Readability Certificate; Arkansas Certification; Arkansas Certification Bulletin 11-83; Copy of Application ENB-7-07 Approved on 8/3/07; Copy of EWEB-67-10 Approved on 2/17/10; Actuarial Memorandum

Company and Contact

Filing Contact Information

Susan Patturelli, Director, IB Contract Support
 501 Boylston Street
 Boston, MA 02116
 SPatturelli@metlife.com
 617-578-3877 [Phone]
 617-578-5505 [FAX]

Filing Company Information

MetLife Investors USA Insurance Company	CoCode: 61050	State of Domicile: Delaware
222 Delaware Ave. Suite 900	Group Code: 241	Company Type: Life
P.O. Box 25130	Group Name: MetLife Group	State ID Number:
Wilmington, DE 19899	FEIN Number: 54-0696644	
(617) 578-2000 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$100.00
Retaliatory?	No
Fee Explanation:	Delaware is our Domiciliary State and their fees are the same as Arkansas so we are sending the Arkansas Fee of \$100.00.
Per Company:	No

Company	Amount	Date Processed	Transaction #
MetLife Investors USA Insurance Company	\$100.00	08/15/2012	61715709

SERFF Tracking #:

METD-128617572

State Tracking #:

Company Tracking #:

CDT 5E-23-12

State:

Arkansas

Filing Company:

MetLife Investors USA Insurance Company

TOI/Sub-TOI:

L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

Term 2012

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5E-23-12 CDT/5E-23-12

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/21/2012	08/21/2012

SERFF Tracking #:

METD-128617572

State Tracking #:**Company Tracking #:**

CDT 5E-23-12

State:

Arkansas

Filing Company:

MetLife Investors USA Insurance Company

TOI/Sub-TOI:

L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

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Disposition

Disposition Date: 08/21/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Arkansas Certification Bulletin 11-83		Yes
Supporting Document	Arkansas Certificate of Compliance		Yes
Form	Term Life Insurance Policy		Yes
Form	Endorsement		Yes

SERFF Tracking #:

METD-128617572

State Tracking #:

Company Tracking #:

CDT 5E-23-12

State: Arkansas

Filing Company:

MetLife Investors USA Insurance Company

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Form Schedule

Lead Form Number: 5E-23-12

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		5E-23-12-ARCTWVWY	POL	Term Life Insurance Policy	Initial:	55.600	5E-23-12-ARCTWVWY.pdf
2		5E-110-12	POLA	Endorsement	Initial:	50.400	5E-E110-12.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



MetLife Investors USA Insurance Company

POLICY NUMBER: [SPECIMEN]

INSURED: [JOHN MIDDLE DOE]

TERM LIFE INSURANCE POLICY

Non-Participating

This is a yearly renewable term insurance policy that is automatically renewable until the Final Expiry Date. Premiums are payable for a specified period. Premiums for the first year are shown on the Policy Specifications page and for later years are shown on the Schedule of Renewal Premiums page. If the Insured dies while the Policy is in force, we will pay the Policy Proceeds to the Beneficiary. We must receive proof of the Insured's death. Any payment will be subject to all of the provisions of the Policy.

RIGHT TO EXAMINE POLICY

Please read the Policy. You may return the Policy to us or to our representative through whom it was purchased within [10] days from the date you receive it. If you return it within this period, we will refund any premium paid and the Policy will be void from the start.

This Policy is a legal contract between the Owner and MetLife Investors USA Insurance Company. PLEASE READ YOUR CONTRACT CAREFULLY.

Signed for the Company at its Main Administrative Office, Irvine, CA 92614

President

Secretary

ALPHABETIC GUIDE TO YOUR CONTRACT

Section	Section
4 Addition of Riders	8 Minimum Payments under Payment Options
1 Application	4 Misstatement of Age or Sex
5 Assignments	7 Other Payment Options and Frequencies
5 Beneficiary	5 Owner
4 Change in Risk Classification	1 Paid to Date
5 Change of Owner or Beneficiary	6 Payee
6 Choice of Payment Options; Option Date	6 Payment
4 Claims of Creditors	6 Payment of Benefits
4 Contract	3 Payment of Premiums
6 Death of Payee	7 Payment Options
4 Decrease in Face Amount	5 Persons with an Interest in the Policy
1 Definitions	1 Policy Date
1 Designated Office	2 Policy Proceeds
5 Designation of Owner and Beneficiary	1, 3 Premiums
1 Final Expiry Date	4 Refund of Unearned Premiums
4 General Provisions	3 Reinstatement
3 Grace Period	3 Renewal
1 In Writing	7, 8 Single Life Income
4 Incontestability	7, 8 Single Life Income – 10 Year Guaranteed Payment Period
1 Insured	4 Statements in Application
1 Issue Age	4 Suicide Exclusion
1 Issue Date	4 Unisex Basis
7, 8 Joint and Survivor Life Income	1 We, Us and Our
6 Life Income Options	1 You and Your
8 Life Income Tables	
6 Limitations	

Riders, Endorsements and Amendments, if any, and copies of the Application follow the final section of the Policy.

POLICY SPECIFICATIONS

Insured [JOHN MIDDLE DOE]
Policy Number [SPECIMEN]
Policy Date [NOVEMBER 15, 2012]
Issue Date [NOVEMBER 15, 2012]
Final Expiry Date [NOVEMBER 15, 2072]
Issue Age of Insured [35]
Sex [MALE]
Minimum Face Amount [\$100,000]
Minimum Face Amount Decrease [\$5,000]
Minimum Installment Amount [\$50.00]

Benefits - As specified in Policy and in any rider

Schedule of Benefits and Premiums

Benefit	Face Amount/ Benefit Amount	First Year [Annual] Premium*	Risk Classification
[YEARLY RENEWABLE TERM WITH GUARANTEED PREMIUMS FOR [10] YEARS]	[\$100,000]	[\$435.00]	[STANDARD SMOKER]

Total Premium Due on Policy Date:

[Annual]

[\$435.00]

*An [\$69.00] annual Policy Fee is reflected in these amounts.

We may offer you promotional programs.

(SEX-DISTINCT BASIS)

SCHEDULE OF RENEWAL PREMIUMS

Insured: [JOHN MIDDLE DOE]

Policy Number: [SPECIMEN]

[Annual] Renewable Premiums

[Policy Year	Term*	Total Premium
[2	\$435.00	\$435.00
3	435.00	435.00
4	435.00	435.00
5	435.00	435.00
6	435.00	435.00
7	435.00	435.00
8	435.00	435.00
9	435.00	435.00
10	435.00	435.00
11	983.00	983.00
12	1,067.00	1,067.00
13	1,161.00	1,161.00
14	1,213.00	1,213.00
15	1,273.00	1,273.00
16	1,359.00	1,359.00
17	1,461.00	1,461.00
18	1,601.00	1,601.00
19	1,759.00	1,759.00
20	1,957.00	1,957.00
21	2,181.00	2,181.00
22	2,409.00	2,409.00
23	2,651.00	2,651.00
24	2,841.00	2,841.00
25	3,061.00	3,061.00
26	3,327.00	3,327.00
27	3,657.00	3,657.00
28	4,055.00	4,055.00
29	4,497.00	4,497.00
30	4,949.00	4,949.00
31	5,395.00	5,395.00
32	5,825.00	5,825.00
33	6,243.00	6,243.00
34	6,683.00	6,683.00
35	7,119.00	7,119.00]

*An [\$69.00] annual Policy Fee is reflected in these amounts.

SCHEDULE OF RENEWAL PREMIUMS (CONTINUED)

Insured: [JOHN MIDDLE DOE]

Policy Number: [SPECIMEN]

[Annual] Renewable Premiums*

[Policy Year	Term *	Total Premium
36	\$ 7,647.00	\$ 7,647.00
37	8,225.00	8,225.00
38	9,011.00	9,011.00
39	9,801.00	9,801.00
40	10,599.00	10,599.00
41	11,527.00	11,527.00
42	12,515.00	12,515.00
43	13,657.00	13,657.00
44	14,977.00	14,977.00
45	16,479.00	16,479.00
46	18,083.00	18,083.00
47	19,879.00	19,879.00
48	21,691.00	21,691.00
49	23,591.00	23,591.00
50	25,657.00	25,657.00
51	28,087.00	28,087.00
52	30,747.00	30,747.00
53	33,607.00	33,607.00
54	36,613.00	36,613.00
55	39,723.00	39,723.00
56	42,895.00	42,895.00
57	45,755.00	45,755.00
58	48,673.00	48,673.00
59	51,689.00	51,689.00
60	54,817.00	54,817.00]

*An [\$69.00] annual Policy Fee is reflected in these amounts.

1. DEFINITIONS

Application	The application(s) including any amendments and supplements for: the Policy; any riders that are made a part of the Policy; and any Policy changes. A copy of the Application is attached to the Policy.
Attained Age	The Issue Age plus the number of completed policy years. This includes any period during which the Policy was lapsed.
Designated Office	Our Main Administrative Office or any other office we designate.
Final Expiry Date	The Final Expiry Date is shown on the Policy Specifications page. It is the date on which the Policy can no longer be renewed. This is the date the Policy is terminated.
In Writing	In a written form satisfactory to us and received at our Designated Office.
Insured	The person whose life is insured under the Policy. The name of the Insured is shown on the Policy Specifications page.
Issue Age	The age of the Insured as of his or her birthday nearest to the Policy Date. The Issue Age is shown on the Policy Specifications page.
Issue Date	The Issue Date is shown on the Policy Specifications page. It is the date from which the incontestability and suicide periods for the coverage are measured.
Paid to Date	The date to which the premiums for the Policy are paid.
Policy Date	The Policy Date is shown on the Policy Specifications page. Policy years, months and anniversaries are all measured from the Policy Date.
Premiums	Premiums are payments to us. Your first premium is due as of the Policy Date. If premiums are paid on an annual mode, the due date for premiums after the first is the policy anniversary each year. If premiums are paid on other than an annual mode, the due date is each semi-annual, quarterly or monthly anniversary as applicable.
We, Us and Our	MetLife Investors USA Insurance Company.
You and Your	The Owner of the Policy.

2. POLICY PROCEEDS

Policy Proceeds

We will pay the Policy Proceeds to the Beneficiary upon receipt of proof of the Insured's death. The Policy Proceeds are equal to:

1. The Face Amount; plus
2. Any insurance on the life of the Insured provided by a rider; plus
3. Any part of a premium paid for coverage beyond the date of death; less
4. Any premium due to the date of death.

In no event will the amount payable upon the death of the Insured be less than the minimum amount required to permit the Policy to qualify as life insurance under the applicable Federal income tax rules.

3. PREMIUMS AND GRACE PERIOD

Payment of Premiums

The first premium is due as of the Policy Date. While the Insured is living, premiums after the first premium must be paid at our Designated Office. The Policy will not be in force until the first premium is paid. If you are in possession of the Policy, and the first premium has not been paid, it will be considered that you have the Policy for inspection only.

Premiums for the Policy and for any riders are shown on the Policy Specifications and on the Schedule of Renewal Premiums pages. No premium is due or payable for any period after the death of the Insured.

Payment can be at any premium mode we make available. A change in premium mode will be processed on the Paid to Date on or following the date we approve your request to change the mode.

Renewal

The Policy will be renewed automatically for successive periods of one year from the Policy Date until the Final Expiry Date shown on the Policy Specifications page.

Grace Period

There is a Grace Period of 31 days in which to pay each premium, without interest, after its due date. The insurance remains in force during the Grace Period. If the premium remains unpaid at the end of the Grace Period, the Policy will lapse as of the due date of the premium in default.

Reinstatement

Prior to the Final Expiry Date, you may reinstate your lapsed Policy (excluding riders) within three years after the date of lapse. Riders can be reinstated only as stated in the rider or with our consent. To reinstate, you must submit a request In Writing and the following:

1. Proof that the Insured is insurable by our standards, and
2. Payment of each unpaid premium while the Insured is living, plus interest at the rate of 6% per year compounded yearly.

The Insured must be alive on the date we approve the request for reinstatement. If the Insured is not alive, such approval is void.

The reinstated Policy will be in force from the date we approve the reinstatement application.

4. GENERAL PROVISIONS

The Contract	<p>We have issued the Policy in consideration of the Application and payment of premiums. The Policy includes the Application, any riders, and any endorsements. Together they comprise the entire contract and are made a part of the Policy when the insurance applied for is accepted. The Policy may be changed by mutual agreement. Any change must be in writing and approved by our President, Vice President or Secretary. Our representatives have no authority to alter or change any terms, conditions, or agreements of the Policy, or to waive any of its provisions.</p> <p>If we make any payment or any policy changes in good faith, relying on our records or evidence supplied to us, our duty will be fully discharged. We reserve the right to correct any errors in the Policy.</p>
Statements in Application	<p>All statements made by the Insured or on his or her behalf, or by the applicant, will be deemed representations and not warranties. Material misstatements will not be used to void the Policy or any rider or to deny a claim unless made in the Application.</p>
Claims of Creditors	<p>To the extent permitted by law, neither the Policy nor any payment under it will be subject to the claims of creditors or to any legal process.</p>
Misstatement of Age or Sex	<p>If we determine that there was a misstatement of age or sex reflected in the Policy, the Face Amount will be the amount the most recent premium paid would have provided based on the correct information.</p>
Unisex Basis	<p>If the Policy is issued on a unisex basis, all rates, benefits and values that contain differences based on sex are modified to provide the same for males and females. See bottom of page 3 for the indication of whether the Policy is issued on a sex-distinct or unisex basis.</p>
Refund of Unearned Premiums	<p>If you ask to discontinue this Policy, we will refund the part of the premium paid for coverage beyond the policy month in which you make your request.</p>
Incontestability	<p>We cannot contest the coverage after the Policy has been in force during the lifetime of the Insured for two years from its Issue Date. This provision will not apply to any rider that contains its own incontestability clause.</p>
Suicide Exclusion	<p>If the Insured dies by suicide, while sane or insane, within two years from the Issue Date, the amount payable will be limited to the amount of premiums paid (without interest), or the reserve if greater and required by state law.</p>
Change in Risk Classification	<p>You may apply for a better risk classification by making a request In Writing to us. Proof of insurability will be required. If we approve your request, the change will take effect on the date we approve your request.</p>
Addition of Riders	<p>You may request in Writing that we add a rider to the Policy. Proof of insurability may be required. If we approve your request, the addition of the rider will take effect on the earlier of the Paid to Date or the current date.</p>

Decrease in Face Amount

After the first policy year and prior to the Final Expiry Date, you may request In Writing that we decrease the Face Amount subject to the following:

1. The effective date of the decrease will be the earlier of: the Paid to Date or the current date.
2. If premiums were paid beyond the effective date of the decrease, any excess premiums will be refunded (without interest).
3. The Face Amount after the requested decrease may not be less than the Minimum Face Amount shown on the Policy Specifications page.
4. The decrease must be at least equal to the Minimum Face Amount Decrease shown on the Policy Specifications page.
5. A decrease in Face Amount may require a decrease in amounts provided by any riders made a part of the Policy. If a rider is not available at the new Face Amount, we will consider your request for a decrease in Face Amount as a request In Writing to terminate that rider.

If you have an increasing term rider on this Policy and you request a decrease in Face Amount, the face amount of that rider will be decreased first.

5. PERSONS WITH AN INTEREST IN THE POLICY

Owner

The Owner of the Policy is named in the Application. The Owner can be changed before the death of the Insured. The new Owner will succeed to all of the rights of the Owner, including the right to make a further change of Owner. If there is more than one Owner, all must exercise the rights of ownership by joint action. Ownership may be changed in accordance with the Change of Owner or Beneficiary provision.

The Owner may be the Insured or someone else, and may be a person, a partnership, a corporation, a fiduciary or any other legal entity. At the death of the Owner, his or her estate will be the Owner, unless a successor Owner has been named. The rights of the Owner will end at the death of the Insured, except as provided in the Beneficiary provision.

Beneficiary

The Beneficiary is the person or entity named to receive the Policy Proceeds. The initial Beneficiary is named in the Application. You can change the Beneficiary before the death of the Insured; however, an irrevocable Beneficiary cannot be changed without his or her consent. The Beneficiary can be a person, a partnership, a corporation, a fiduciary or any other legal entity. The Beneficiary has no interest in the Policy until the death of the Insured. A person must survive the Insured to qualify as Beneficiary. If no Beneficiary survives, the proceeds will be paid to the Owner.

Any payment we make will terminate our liability with respect to such payment.

Change of Owner or Beneficiary

During the Insured's lifetime, you may change the Owner and Beneficiary designations, subject to any restrictions as stated in the Owner and Beneficiary provisions. You must make the change In Writing. Once it is recorded, the change will take effect as of the date you signed the request, whether or not the Insured is living when we receive your request. The change will be subject to any assignment of the Policy or other legal restrictions. It will also be subject to any payment we made or action we took before we recorded the change. A change of Owner will void any prior Beneficiary designation.

Assignments

If you make an absolute assignment of the Policy, the assignee will be the new Owner and Beneficiary. A collateral assignment of the Policy by you is not a change of Owner or Beneficiary; but their rights will be subject to the terms of the collateral assignment. Assignments will be subject to all payments made and actions taken by us before a signed copy of the assignment form is recorded by us at our Designated Office. We will not be responsible for determining whether or not an assignment is valid.

Designation of Owner and Beneficiary

A numbered sequence can be used to name successive Owners or Beneficiaries. Co-beneficiaries will receive equal shares unless otherwise stated.

In naming Owners or Beneficiaries, unless otherwise stated:

1. "Child" includes an adopted or posthumous child;
2. "Provision for issue" means that if a Beneficiary does not survive the Insured, the share of the Policy Proceeds for that Beneficiary will go to his or her living issue by right of representation; and
3. A family relation such as "wife", "husband" or "child" means in relation to the Insured.

At the time of payment of benefits, we can rely on an affidavit of any Owner or other responsible person to determine family relations or members of a class.

6. PAYMENT OF BENEFITS

Payment	<p>Unless otherwise requested, when the Insured dies we will pay the Policy Proceeds to the Payee in one sum, which includes placing the amount in an account that earns interest. If an account is established, the Payee will be the accountholder and will have immediate access to all of the account. The proceeds may include interest as required by applicable law.</p> <p>On request, all or part of the proceeds payable in one sum at the death of the Insured can be applied to any Payment Option at the choice of the Payee. Further, with our consent, any Payee who is entitled to receive proceeds in one sum when a Payment Option ends, or at the death of a prior Payee, or when the proceeds are withdrawn, can choose to apply the proceeds to a Payment Option.</p>
Choice of Payment Options; Option Date	<p>The choice of a Payment Option and the naming of the Payee must be In Writing. You can make, change or revoke the choice before the death of the Insured. The Option Date is the effective date of the Payment Option, as chosen.</p> <p>When a Payment Option starts, a contract will be issued by us or by an affiliate that will describe the terms of the Option.</p>
Payee	<p>A Payee is a person, a partnership, a corporation, a fiduciary or any other legal entity entitled to receive the Policy Proceeds in one sum or under a Payment Option.</p> <p>If the Payee is not a natural person, the choice of a Payment Option will be subject to our approval. A collateral assignment will modify a prior choice of a Payment Option. The amount due any assignee will be payable in one sum and the balance will be applied under the Payment Option.</p>
Life Income Options	<p>Guaranteed Life Income Options are based on the age of the Payee on the Option Date. We will require proof of age. The Life Income payments will be based on the rates shown in the Life Income Tables; or, if they are greater, our Payment Option rates on the Option Date. If the rates at a given age are the same for different periods certain, the longest period certain will be deemed to have been chosen.</p>
Death of Payee	<p>Amounts to be paid after the death of a Payee under a Payment Option will be paid as due to the successor Payee. If there is no successor Payee, amounts will be paid in one sum to the estate of the last Payee to die. If a Payee under a Life Income Option dies within 30 days after the Option Date, the amount applied to the Option, less any payments made, will be paid in one sum, unless a Payment Option is chosen.</p>
Limitations	<p>If installments under an Option would be less than the Minimum Installment Amount shown on the Policy Specifications page, proceeds can be applied to a Payment Option only with our consent.</p>

7. PAYMENT OPTIONS

Single Life Income	Monthly payments will be made during the lifetime of the Payee.
Single Life Income – 10 Year Guaranteed Payment Period	Monthly payments will be made during the lifetime of the Payee with a guaranteed payment period of 10 years.
Joint and Survivor Life Income	Monthly payments will be made: <ol style="list-style-type: none">1. While either of two Payees is living, called “Joint and Survivor Life Income”; or2. While either of two Payees is living, but for at least 10 years, called “Joint and Survivor Life Income, 10 Years Certain”.
Other Payment Options and Frequencies	Other Payment Options and payment frequencies may be arranged with us.

8. LIFE INCOME TABLES

Minimum Payments under Payment Options

Monthly payments for each \$1,000 applied will not be less than the amounts shown in the following Tables. On request, we will provide additional information about amounts of minimum payments. The amounts shown below are based on an interest rate of ½ percent a year and the 2000 Annuity Mortality Table.

Single Life Income

Payee's Age	Life Income			10 Year Guaranteed Payment Period		
	Male	Female	Unisex	Male	Female	Unisex
50	\$2.32	\$2.15	\$2.22	\$2.32	\$2.15	\$2.21
55	2.60	2.39	2.47	2.59	2.38	2.46
60	2.96	2.69	2.79	2.93	2.68	2.78
65	3.41	3.08	3.21	3.36	3.06	3.18
70	4.02	3.60	3.76	3.92	3.55	3.69
75	4.86	4.31	4.52	4.63	4.20	4.36
80	6.01	5.33	5.58	5.47	5.03	5.20
85	7.62	6.82	7.12	6.39	6.04	6.18
90 & over	9.87	9.04	9.36	7.26	7.06	7.14

Joint and Survivor Life Income

Age of Both Payees	Joint and Survivor		Joint and Survivor, 10 Years Certain	
	One Male and One Female	Unisex	One Male and One Female	Unisex
50	\$1.95	\$1.94	\$1.95	\$1.94
55	2.14	2.14	2.14	2.14
60	2.39	2.38	2.39	2.38
65	2.69	2.69	2.69	2.69
70	3.10	3.09	3.10	3.09
75	3.64	3.63	3.63	3.62
80	4.39	4.37	4.35	4.33
85	5.45	5.42	5.28	5.26
90 & over	6.96	6.93	6.37	6.35

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TERM LIFE INSURANCE POLICY

Non-Participating

ENDORSEMENT

MetLife Investors USA Insurance Company

This Endorsement is a part of the Policy as of the later of: the Issue Date of the Policy; and the date this Endorsement was approved by the state governing the Policy.

Will Preparation Service A Will Preparation Service (called "Service") covers the preparation of a simple or complex will for the Covered Person. The creation of any testamentary trust is covered. The Service includes the preparation of codicils and will amendments. It does not include tax planning. The Service will be provided by Hyatt Legal Plans, Inc. ("Hyatt"), an affiliate of the Company.

The Service will be made available at no additional cost to the Covered Person if a Network Attorney is used. The Service can be used multiple times while the Policy is in force.

Network Attorney A Network Attorney is an attorney designated by Hyatt who will provide the Service.

Out-of-Network Attorney Covered Persons have the option to retain an attorney who does not participate in Hyatt's network of attorneys and to receive reimbursement for the Service up to a set dollar limit. The Covered Person is responsible for any fees over the amount reimbursed. (See the How to Use Service provision below.)

Covered Person A Covered Person is the Insured and the Insured's spouse. The Insured's spouse includes a party to a civil union or domestic partnership, if required by state law.

How to Use Service To use the Service, or to obtain a fee reimbursement schedule, the Covered Person must call Hyatt at [1-800-821-6400].

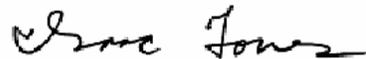
Reinstatement If the Policy lapses and is later reinstated according to the terms of the Policy, this Endorsement will also be reinstated.

Termination This Endorsement will terminate on the earliest of:

1. The date the Policy lapses;
2. The date the Policy terminates; and
3. The date of death of the Insured.

If this Endorsement terminates under items 1. or 2. above, any action initiated under the Service prior to termination will be completed. If this Endorsement terminates under item 3, any action initiated under the Service by the Insured's spouse prior to termination will be completed.

MetLife Investors USA Insurance Company



Secretary

SERFF Tracking #:

METD-128617572

State Tracking #:

Company Tracking #:

CDT 5E-23-12

State:

Arkansas

Filing Company:

MetLife Investors USA Insurance Company

TOI/Sub-TOI:

L04I Individual Life - Term/L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium

Product Name:

Term 2012

Project Name/Number:

5E-23-12 CDT/5E-23-12

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Readability (CDT).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:			
Attachment(s):			
ENB-7-07 SAMPLE.pdf			
EWEB-67-10 (Bracketed-AR,NM,OH,OK6).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Arkansas Certification Bulletin 11-83		
Comments:			
Attachment(s):			
AR Certification (CDT).pdf			

		Item Status:	Status Date:
Satisfied - Item:	Arkansas Certificate of Compliance		
Comments:			
Attachment(s):			
AR Certification of Compliance (CDT).pdf			

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)
5E-23-12-ARCTWVWY	55.6
5E-E110-12	50.4



Karen A. Johnson, Vice President

8/15/2012

Date

Application for Life Insurance

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "the Company".

- Metropolitan Life Insurance Company
New England Life Insurance Company
MetLife Investors Insurance Company
General American Life Insurance Company
MetLife Investors USA Insurance Company

SECTION I - About the Proposed Insured

For Additional Insureds please complete the Additional Insureds Supplement form.

Form fields for Section I: First Name, Middle Name, Last Name, Permanent Address, City, State, Zip, Country of Legal Residence, Date of Birth, E-Mail Address, Primary Phone Number, Alternate Phone Number, Preferred Time to Call, From, To, Sex, Place of Birth, Social Security or Tax ID Number, Earned Annual Income, Net Worth, U.S. Driver's License, Issuer of ID, ID Number, Issue Date, Expiration Date, Name of Employer, Employer City, State, Zip, Position/Duties.

Form fields for 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.

SECTION II - About the Owner

Complete ONLY if the Owner is NOT the Proposed Insured.

Form fields for Section II: OWNER - TRUST / BUSINESS ENTITY (Name of Entity, Tax ID Number, Trustee / Owner State), OWNER - OTHER INDIVIDUAL (First Name, Middle Name, Last Name, Permanent Address, City, State, Zip, Country of Legal Residence, Citizenship, Social Security or Tax ID Number, Date of Birth, Phone Number, E-Mail Address, Earned Annual Income, Net Worth, Relationship to Proposed Insured, Please indicate form of ID, Issuer of ID, ID Number, Issue Date, Expiration Date).

Check if ownership should revert to Insured upon Owner and Contingent Owner's deaths.



SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries, use Section IX - Additional 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)
Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

Check here to include all living and future natural or adopted children of the Proposed Insured as Contingent Beneficiaries. (Name all living children above.)

If a Custodian is acting on behalf of a minor Beneficiary listed above, please use **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

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

SECTION IV - About Proposed Coverage

Check the desired coverage(s).

<input type="checkbox"/> Universal Life	<input type="checkbox"/> Variable Life <input type="checkbox"/>	<input type="checkbox"/> Whole Life	<input type="checkbox"/> Term Life
Product Name _____	Product Name _____	Product Name _____	Product Name _____
Face Amount* _____	Face Amount* _____	Face Amount* _____	Face Amount* _____
Riders and Details _____	Riders and Details _____	Riders and Details _____	Riders and Details _____
<input type="checkbox"/> Coverage Continuation (UL only)			
Disability Waiver: <input type="checkbox"/> Specified Premium _____ <input type="checkbox"/> Monthly Deduction (VUL only) _____	<input type="checkbox"/> Disability Waiver Dividend Options: <input type="checkbox"/> Paid-Up Additions _____ <input type="checkbox"/> Other, please specify: _____	Disability Waiver: <input type="checkbox"/> Convertible <input type="checkbox"/> Non-Convertible	
Death Benefit Option _____	<input type="checkbox"/> Automatic Premium Loan Requested		
Definition of Life Insurance: <input type="checkbox"/> Guideline Premium Test <input type="checkbox"/> Cash Value Accumulation Test			
Planned Premium Year 1 _____ Years 2 to _____ Years _____ to _____ (UL only)	<p>i For a full list of riders and options, please consult with your Producer. Note: Some riders may require supplement forms to be completed.</p> <p><input type="checkbox"/> For Variable Life products, please complete the Variable Life Supplement form. * If Face Amount is equal to or exceeds \$1,000,000, please complete the Personal Financial Information form.</p>		

ADDITIONAL OPTIONS

One Time (Single) Payment Amount 1035 Exchange Amount Requested Policy Date Save Age

POLICY OPTIONS

Alternate Policy: Product, Face Amount and Details _____

Additional Policy: Product, Face Amount and Details _____

Group Conversion Only

Group Conversion Alternative

} Please complete the **Group Conversion Supplement** form for either choice.



SECTION V - About 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

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.

If Proposed Insured is financially dependent on another individual, indicate individual providing support:

Spouse Child Parent Other _____

Amount of insurance on individual providing support. Existing Insurance _____ Insurance Applied For _____

If Proposed Insured is a minor, are all siblings equally insured? Yes No

If **NO**, please provide details: _____

SECTION VI - About 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 is the Payor			
Permanent Address	City	State	Zip

PAYMENT MODE (Check the appropriate ONE.) Billing Mode: Annual Semi-Annual Quarterly

Monthly Draft per Debit Authorization (See next page.)

Monthly Draft per Existing Electronic Payment Number _____

Special Account: Government Allotment Salary Deduction List Bill

If Special Account, provide Employer Group Number (EGN) or List Bill Number _____

INITIAL PAYMENT Method of Collection:

Amount Collected with Application Initial Premium by Electronic Funds Transfer (Must be at least a monthly amount.)

_____ Check (Must be at least 1/12 of an annual premium.)

SOURCE OF CURRENT AND FUTURE PAYMENTS (Check **ALL** that apply.)

Earned Income Mutual Fund/Brokerage Account Money Market Fund Savings Loans

Certificate of Deposit Use of Values in another Life Insurance/Annuity Contract Other _____



DEBIT AUTHORIZATION  Available only if the bank account holder is the Owner and/or Proposed Insured.

 All others please complete the **Electronic Payment (EP) Account Agreement** form.

The undersigned ("I") hereby authorize the Company with whom I am completing this application to initiate debit entries through Metropolitan Life Insurance Company to the deposit account designated below, at the Financial Institution named below, using the Automated Clearing House. I authorize:

1. Monthly recurring debits; AND
2. Debits made from time to time, as I authorize.

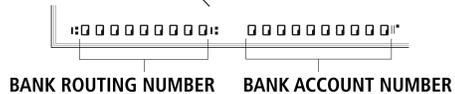
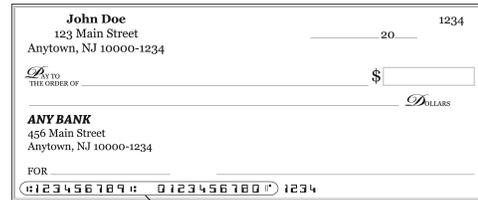
This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and the Financial Institution a reasonable opportunity to act on it.

Monthly Debit Date: Issue Date of the Policy
 Debit Date on the _____ of each month

Bank Account Type: Checking Savings

Bank Routing Number _____ Bank Account Number _____

Name of Financial Institution _____



 Note: Please attach a voided check or deposit slip to Section IX - Additional Information.

We cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services from foreign banks UNLESS the check is being paid in U.S. Dollars through a U.S. correspondent bank (the U.S. correspondent bank name must be on the check).

SECTION VII - General Risk Questions

Use Section IX - Additional Information if necessary.

1. 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.

2. 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.

3. 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**? Yes No

If **YES**, please provide details.

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"/>			

4. Has the Proposed Insured **EVER** used tobacco or nicotine products in any form (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



Certification / Agreement / Disclosure

Was a sales illustration provided for the life insurance policy as applied for?

Yes No

A. If **Yes**, please choose one of the following:

- An illustration was signed and **matches the policy applied for**. It is included with this application.
- An illustration was shown or provided but is **different from the policy applied for**. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- The sale was made using an illustration with Accelerated Payment.
- If illustration was **only shown on a computer screen**, check and complete the details in the box below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) Male Female Unisex
2. Age _____
3. Rating Class (e.g. Standard Non-smoker) _____ Non-smoker Smoker
4. Product Name (e.g. GAUL) _____
5. Face Amount _____
6. Dividend Option (Whole Life only) _____

B. If **No**, please choose one of the following:

- Producer certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.
- No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

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, amendment(s), or any supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or 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 and Consent for HIV Testing, I have received a copy of that Notice.**



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.

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 withholding 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 certifications required to avoid backup withholding.

Signatures

If not witnessing all signatures, witness should initial next to signature being witnessed and sign below.

Signature(s) of all Proposed Insured(s)	Date	Signed at City, State
▶ _____	_____	_____

(age 15 or over)

Please complete the **Additional Insureds Supplement** or **Child Rider Supplement** form(s) if applicable.

Signature(s) of all Owner(s) (If NOT the Proposed Insured.)	Date	Signed at City, State
▶ _____	_____	_____

(age 15 or over)

ⓘ If the Owner is a firm or corporation, include Officer's title with signature.

If Co-Owner or Custodian, please complete the **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

Signature of Parent or Guardian	Date	Signed at City, State
▶ _____	_____	_____

(If Owner or Proposed Insured is under 18, sign here. If not sign above.)

Witness to Signatures

Licensed Producer	Print Name of Producer
▶ _____	_____



* 1 % 1 % 2 % 8 7 % 4 % 1 8 8 7 6 % 7 % 7 % 1 4 % \$ *

Application for Life Insurance

MetLife Investors USA Insurance Company (Referred to as "the Company".)

IS THIS APPLICATION BEING COMPLETED IN THE UNITED STATES? Yes No

SECTION I - About the Proposed Insured

First Name _____ Middle Name _____ Last Name _____ Suffix _____

Street Address _____ City _____ State _____ Zip _____

Country of Legal Residence _____ Date of Birth _____ E-Mail _____

Primary Phone _____ Alternate Phone _____ Gender Male Female _____ Place of Birth (State/Country) _____ Social Security Number _____

U.S. Driver's License Passport State Issued ID Employment Authorization Document (EAD) Card

Issuer of ID _____ ID Number _____ Expiration Date (if any) _____

Are you a U.S. Citizen? Yes No

If NO, Country of Citizenship? _____

How long have you lived in the U.S.? _____

Do you have Permanent Resident status in the U.S.? Yes No

NON U.S. PERMANENT RESIDENTS ONLY - Country of Permanent Residence _____

Do you have a U.S. Visa? Yes No

If YES, U.S. Visa Type _____ Visa Number _____ Expiration Date _____

If NO Visa, do you have an Employment Authorization Document (EAD) Card? Yes No

If YES, what is the EAD Class? _____

If NO EAD Card, do you have a Visa/Immigration application pending with the USCIS? Yes No

If YES, Application Number: _____

SECTION II - Employment

EMPLOYMENT STATUS: Currently Employed Student Homemaker Unemployed

Currently Employed:

Name of Employer _____

Work Address: City _____ State/Country _____

Position/Duties _____

Are you currently working and performing your usual job duties? Yes No

If YES, Annual Income: \$ _____

If NO, why are you unable to work? Physical/Mental Impairment Family Medical Leave

Physical/Mental Impairment:

Why are you unable to work? _____

Do you expect to return to work within [six] months? Yes No Unknown/Unsure

If YES, annual income prior to disability: \$ _____



If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Main Source of Income:

- Long Term Disability Worker's Compensation Charitable Organization Government Assistance
- Social Security Disability Savings/Investments Short Term Disability Family Members
- Other, please enter details. _____

Family Medical Leave:

This leave is related to: Birth/Adoption Family Other

If **BIRTH/ADOPTION** or **FAMILY**, Annual Income: \$ _____

If **OTHER**, please answer the following questions:

Why are you unable to work? _____

Do you expect to return to work within [six] months? Yes No Unknown/Unsure

If **YES**, annual income prior to disability: \$ _____

If **NO/ UNKNOWN/ UNSURE**, please answer the following questions:

Current Annual Income: \$ _____

Main Source of Income:

- Long Term Disability Worker's Compensation Charitable Organization Government Assistance
- Social Security Disability Savings/Investments Short Term Disability Family Members
- Other, please enter details. _____

Student:

Annual Income: \$ _____

What is the main source of your remaining support?

- Parent Grandparent Grants Spouse/Civil Union/Domestic Partner
- Sibling Savings/Investments Student Loans
- Other, please enter details. _____

Homemaker:

Annual Household Income: \$ _____

What is the main source of your household income?

- Parent Grandparent Government Assistance/Social Security Disability Income
- Sibling Savings/Investments Unemployment Benefits Spouse/Civil Union/Domestic Partner
- Other, please enter details. _____

If **YES** to Disability Income, are you receiving disability income due to your personal disability? Yes No

If **YES**, why are you unable to work? _____

Unemployed:

What is the main source of your income?

- Parent Grandparent Government Assistance/Social Security Disability Income
- Sibling Savings/Investments Unemployment Benefits Spouse/Civil Union/Domestic Partner
- Other, please enter details. _____

Annual Income: \$ _____

If **YES** to Disability Income, are you receiving disability income due to your personal disability? Yes No

If **YES**, why are you unable to work? _____

Do you expect to return to work within [six] months? Yes No Unknown/Unsure

If **YES**, annual income prior to disability: \$ _____

Have you been previously employed? Yes No



If **YES**, please answer the following questions.

What was your last date of employment? _____

What was the name of your employer? _____

What was your position/duties? _____

How long did you work there? _____

What was your annual income with your former employer? _____

If **NO**, are you a student?

Yes No

Will you pay for this life insurance policy with your earned income (for example, annual salary)?

Yes No

If **NO**, what is the source of the payments for this life insurance policy?

- Savings/Investments Grandparent Parent Spouse/Civil Union/Domestic Partner
- Sibling Loans Use of Values from another Life Insurance/Annuity Contract
- Other - Please enter details: _____

SECTION III - Beneficiary

Beneficiary Type: Individual Trust

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

Check here to include all living and future natural or adopted children as Contingent Beneficiaries. (Name all living children above.)

Trust Name _____

Social Security Number/TIN _____ Date Established _____ % of Proceeds _____

Beneficiary Type Primary Contingent

Trustee Name _____

Address _____

City _____ State _____ Zip _____

SECTION IV - Existing or Applied-for Coverage

1. Do you have any existing or applied-for life insurance or annuities with this or any other company? Yes No

If **YES**, please provide details about your existing **Life** insurance and any **Life** insurance policies you have applied for.

Company	Amount of Insurance	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

2. By applying for this life insurance policy, do you plan to cancel, withdraw money from, take a loan from, reduce premium payments for, or otherwise change an existing life insurance policy or annuity? Yes No



3. Have you ever had an application for life, disability income or health insurance declined, postponed (temporarily declined), issued/offered with an increase in premium or modified due to risk factors? Yes No

If **YES**, please fill in the details below:

Type of Insurance: Life/Health/ Disability	Action Taken (Declined, Postponed, Increased Premium, Modified)	Reason for Action (Medical, occupation, foreign travel, residence, aviation, hazardous sports, driving, other, unknown/unsure)	Year Action Occurred

SECTION V - Payment Information

Who is paying for this policy? Self Other
 If Other, please answer the following: Payor Name _____ Relationship to Proposed Insured (You) _____

Please enter Billing Address if different from your Residence Address.
 Billing Address _____
 City _____ State _____ Zip _____

PAYMENT METHOD (Check the appropriate ONE.)

[Electronic Funds Transfer]
 How often do you want to make your payments? Annually Semi-Annually Quarterly Monthly
 Existing Electronic Payment Number _____
 If you are the bank account holder, please fill out the following bank account information. If the Other Payor is the bank account holder, the Other Payor must complete the Electronic Payment (EP) Account Agreement form.
 Name of Financial Institution: _____
 Bank Account Type: Checking Savings
 Bank Routing Number: _____ Bank Account Number: _____
 Debit will take place this date: _____
 Amount Collected with Application: _____ (Must be at least 1/12 of an annual premium.)

[Direct Bill/Check]
 How often do you want to make your payments? Annually Semi-Annually Quarterly
 Amount Collected with Application: _____ (Must be at least 1/12 of an annual premium.)

[Debit/Credit Card]
 How often do you want to make your payments? Annually Semi-Annually Quarterly Monthly
 [Visa] [MasterCard] [American Express] [Discover]
 Account Number: _____ Expiration Date: _____ [CCV #:] _____

SECTION VI - General Questions

1. In the past [three] years, have you flown in a plane other than as a passenger on a commercial airline or do you have plans to do so in the next 12 months? Yes No

2. In the past [three] years, have you participated in or do you plan to participate in **any** of the following? Check **ALL** that apply.

Underwater sports - SCUBA diving, skin diving, or similar activities Outdoor rock or mountain climbing or similar activities
 Racing sports - motorcycle, auto, motor boat or similar activities Bungee jumping or similar activities
 Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities
 None of the Above

In the past 24 months have you participated in or do you plan in the next 12 months to participate in any of these activities outside of the United States/Canada? Yes No



3. Have you ever been convicted of or pled Guilty or No Contest to a felony?

Yes No

If **YES**, please answer the following:

Are you currently incarcerated?

Yes No

Are you currently on parole or probation?

Yes No

Was a weapon used in the commission of the felony?

Yes No

Date of Conviction: _____ Location of Offense: City _____ State _____

Name of Court: _____

Location of Court: City _____ State _____

What charges were you convicted of? _____

Was any penalty imposed?

Yes No

If **YES**, please provide details. _____

4. Have you ever had a driver's license suspended or revoked, ever been convicted of DUI or DWI, or had any moving violations in the past [five] years?

Yes No

If **YES** - Please check **ALL** that apply:

Suspended/Revoked DUI or DWI Moving Violations in the past [five] years

Suspended/Revoked:

Date of Offense: _____ Location of Offense: City _____ State _____

Name of Court: _____

Location of Court: City _____ State _____

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?

Was any penalty imposed?

Yes No

If **YES**, please provide details. _____

Were there any other related charges?

Yes No

If **YES**, please provide details for related charges below.

Date of Offense: _____ Location of Offense: City _____ State _____

Name of Court: _____

Location of Court: City _____ State _____

What was the offense (speeding, reckless driving, DUI/DWI, leaving the scene of an accident, vehicular homicide, other)?

Was any penalty imposed?

Yes No

If **YES**, please provide details. _____

Were there any accident(s) involved?

Yes No

If **YES**, please answer the following:

Were there damages to persons, property, or both?

Yes No

If **YES**, please select:

Person(s) Property Both

Were there any fatalities involved?

Yes No

Please provide results of any legal proceedings. _____



DUI or DWI:

How many times have you been convicted of DUI/DWI? _____

Date of DUI/DWI: _____ Location of Offense: City _____ State _____

Driver's License Number Involved: _____

Were there any other related charges? Yes No

If **YES**, please provide details for related charges below.

Date of Offense: _____ Location of Offense: City _____ State _____

Name of Court: _____

Location of Court: City _____ State _____

What was the offense (speeding, reckless driving, leaving the scene of an accident, vehicular homicide, other)?

Was any penalty imposed? Yes No

If **YES**, please provide details. _____

Were there any accident(s) involved? Yes No

If **YES**, please answer the following:

Were there damages to persons, property, or both? Yes No

If **YES**, please select: Person(s) Property Both

Were there any fatalities involved? Yes No

Please provide results of any legal proceedings.

Has your license been suspended? Yes No

If **YES**, please provide current status: Active Inactive Suspended Revoked Other

If **Other**, please provide details. _____

What were you under the influence of? Drugs Alcohol Both

Alcohol/Both

A. Describe your current alcohol consumption:

How often do you drink alcohol? _____

How many drinks do you have on a typical day when you are drinking? _____

In the past [three] months how often did you have more than four drinks in one day? _____

B. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? _____

How many drinks did you have on a typical day when you were drinking? _____

In a typical 12 month period, how often did you have more than four drinks in one day? _____

C. Are you currently in a support group? Yes No



5. Have you **traveled** or **resided** outside of the U.S. or Canada in the past 24 months; or do you plan to **travel** or **reside** outside of the U.S or Canada in the next 12 months?

Yes No

If **YES**, please provide details.

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

If **YES**, please provide the information below for planned future travel.

- A. Do you plan to participate in any missionary, journalistic, diplomatic, or medical work? Yes No
- B. What cities/regions of this country will you be visiting? _____
- C. What activities have you planned while visiting this country? _____
- D. Do you plan to visit non-urban areas? Yes No
- E. Will you consider visiting war zones or hazardous areas of this country? Yes No
- F. What is the availability of medical facilities, if needed? _____
- G. What type of transportation will you use for travel to and from the area? _____
- H. Will you be attending a conference/seminar sponsored by a corporation, foundation or industry group or something similar? Yes No
- I. Will you be staying at an all-inclusive resort? Yes No
- J. What is the name of the resort? _____
- K. What type of accommodations will you stay in? _____
- L. Will you be going on an expedition/safari? Yes No
- M. Will you be traveling with a group? Yes No
- N. What travel company is hosting the trip? _____
- O. How large is the group? _____
- P. Are there any special security arrangements to help ensure the group's safety? Yes No

6. In the past [five] years, have you used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)?

Yes No

If **YES**, type of product used:

Product(s)	Date Last Used

If Cigars, number per year: _____



SECTION VII - Health Questions

1. Height (ft. in.) _____ Weight (lbs.) _____

2. Have you ever been diagnosed, received treatment, or consulted with a health care professional for any of the following? Check **ALL** that apply.

- High Blood Pressure High Cholesterol Cancer Diabetes Rheumatoid Arthritis Systemic Lupus
- Neurological Disorder (Mental Retardation, Multiple Sclerosis, Paralysis, Seizures, Other) (excluding headaches and migraine headaches)
- Emotional or Psychological Disorder (Anxiety, Depression, Eating Disorder, Other)
- None of the Above

HIGH BLOOD PRESSURE:

In the past [10] years, have you been hospitalized for high blood pressure?

Yes No

If **NO**, please answer the following.

A. Are you taking any medications for high blood pressure?

Yes No

If **YES**, please list medications. _____

B. Have you had your blood pressure taken in the past [12] months?

Yes No

If **YES**, do you remember your most recent blood pressure reading?

Yes No

If **YES**, what was the reading? _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

HIGH CHOLESTEROL:

A. Have you had your cholesterol tested in the past [12] months?

Yes No

If **YES**, please answer the following.

Do you know the results of your most recent cholesterol reading?

Yes No

If **YES**, please enter the reading: _____

B. Are you taking any medications for cholesterol?

Yes No

If **YES**, please list medications. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

CANCER:

A. Are you currently receiving any treatment for the cancer?

Yes No

B. What was the location and type of cancer?

Location _____ Type _____ Check if Unknown

C. When was the cancer diagnosed? Date _____



D. What was the stage of cancer you had:

- Stage 0 Stage 1 Stage 2 Stage 3 Stage 4 Unknown

E. Had the cancer spread to your lymph nodes or any other site?

Yes No

F. What treatments did you receive for the cancer? Check **ALL** that apply.

- Chemotherapy Radiation Surgery
- Other, please explain _____

G. When was the treatment completed? Date _____

Yes No

H. Has there ever been a recurrence of the cancer?

I. Has any other treatment, surgery, testing or other follow-up (other than your regular check-up) been discussed, suggested or planned for the cancer?

Yes No

If **YES**, please provide details. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

DIABETES:

A. Did you have diabetes only during pregnancy?

Yes No

If **YES**, please complete the following.

Are you currently pregnant?

Yes No

If **NO**, please complete the following.

Are you currently being treated for diabetes?

Yes No

If **NO**, please complete the following.

Has your blood sugar returned to normal?

Yes No

B. In the past [five] years, have you been hospitalized for diabetes?

Yes No

C. Have you ever been diagnosed as having kidney disease or protein in your urine?

Yes No

D. Have you ever been diagnosed as having Retinopathy or Diabetic related eye problems?

Yes No

E. Have you ever been diagnosed as having Diabetic related neuropathy?

Yes No

F. Have you had any other complications of diabetes (skin infections, poor circulation, other)?

Yes No

If **YES**, please provide details. _____

G. How old were you when the diabetes was diagnosed? _____

H. Have you had a check-up with a health care professional for diabetes in the past [12] months?

Yes No

I. Are you taking any medications for diabetes?

Yes No

If **YES**, please list medications. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



RHEUMATOID ARTHRITIS:

A. Have you been diagnosed as having heart, lung, or kidney problems related to rheumatoid arthritis? Yes No

B. Are you taking any medications for rheumatoid arthritis? Yes No

If **YES**, please list medications. _____]

Have you had any changes to your medications in the past [12] months? Yes No

If **YES**, please provide details. _____]

C. Have you had any joints replaced? Yes No

If **YES**, please provide details. _____]

D. Are you limited in any activities due to rheumatoid arthritis? Yes No

If **YES**, please provide details. _____]

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to rheumatoid arthritis? _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

NEUROLOGICAL DISORDER:

If **YES**, what was the diagnosis? Check **ALL** that apply.

Mental Retardation Multiple Sclerosis Paralysis Seizures

Other - Please answer the questions in **Section X - Other**.

Multiple Sclerosis:

A. Were you diagnosed with multiple sclerosis in the past [12] months? Yes No

B. How old were you when the multiple sclerosis was diagnosed? _____

C. Have you been hospitalized in the past [three] years for multiple sclerosis? Yes No

D. Are you able to walk? Yes No

[If **YES**, do you require an aid (cane, walker, other)?] Yes No

E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to multiple sclerosis? _____

F. Are you currently taking or have you taken in the past 12 months any medications for multiple sclerosis? Yes No

If **YES**, please list medications. _____]

G. In the past [24] months have you had any symptoms of multiple sclerosis? Yes No

If **YES**, please describe your symptoms. _____]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



Paralysis:

- A. Was this Bell's Palsy only? Yes No
- B. Was the onset of the paralysis in the past 12 months? Yes No
- C. Was the paralysis caused by trauma or an accident? Yes No

If **YES**, please provide details. _____]

D. What part of your body is affected by this condition (one arm, both arms, one leg, both legs, other)?

- E. Are you able to walk? Yes No

If **YES**, do you require an aid (cane, walker, other)? _____]

If **YES**, please provide details. _____]

- F. Do you use a urinary catheter? Yes No

- G. Do you have any kidney impairment other than kidney stones? Yes No

- H. Do you have any complications such as infections, skin ulcers or kidney stones? Yes No

If **YES**, please provide details. _____]

If **YES**, are you receiving any treatment for the complications? _____]

If **YES**, please provide details. _____]

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Seizures:

A. What type of seizures do you have? Check **ALL** that apply.

- Tonic-clonic/Grand mal
- Absence/Petit mal
- Focal/Partial
- Febrile
- Unknown
- Other - Please provide details. _____

- B. Is there a known cause for the seizures? Yes No

If **YES**, please provide details. _____]

C. How old were you when the seizures were diagnosed? _____

- D. Was your last seizure in the past 12 months? Yes No

If **YES**, how many seizures did you have in the past 12 months? _____]

If **NO**, date of last seizure: _____]

- E. Are you taking any medications for seizures? Yes No

If **YES**, please list medications. _____]

- F. Have you had any changes to your medications in the past 12 months? Yes No

If **YES**, please provide details. _____]

- G. Have you had any surgery for seizures? Yes No

If **YES**, date of surgery? _____]

- H. Are you prevented from holding a driver's license or are your activities restricted in any other way due to seizures? Yes No

If **YES**, please provide details. _____]



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

EMOTIONAL OR PSYCHOLOGICAL DISORDER:

If **YES**, what was the diagnosis? Check **ALL** that apply.

Yes No

Anxiety Depression Eating Disorder Other - Please answer the questions in **Section X - Other**.

Anxiety:

A. Have you been hospitalized in the past [five] years for anxiety?

Yes No

B. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anxiety? _____

C. Have you ever attempted to end your life?

Yes No

D. Are you taking any medications for anxiety?

Yes No

If **YES**, please list medications. _____

E. Have you had any changes to your medications in the past 12 months?

Yes No

If **YES**, please provide details. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Depression:

A. Have you ever been diagnosed with bipolar disease or manic depression?

Yes No

B. Have you been hospitalized in the past [five] years for depression?

Yes No

C. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to depression? _____

D. Have you ever attempted to end your life?

Yes No

E. Are you taking any medications for depression?

Yes No

If **YES**, please list medications. _____

F. Have you had any changes to your medications in the past 12 months?

Yes No

If **YES**, please provide details. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



Eating Disorder:

If **YES**, what type of eating disorder? Check **ALL** that apply.

- Anorexia Nervosa
- Bulimia
- Other - Please provide details. _____

A. Are you currently in remission?

Yes No

If **YES**, how long have you been in remission? _____

B. How old were you when this eating disorder began? _____

C. Have you ever had any relapses (eating disorder went into remission but then recurred)?

Yes No

If **YES**, how many relapses have you had? _____

D. How long have you been at your current weight? _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

3. Other than as indicated above, have you ever had any disease or disorder of any of the following? Check **ALL** that apply.

- Heart (Congenital Heart Disease, Coronary Artery Disease, Heart Attack, Heart Murmur, Valvular Heart Disease, Other)
- Arteries / Veins (Aneurysm, Carotid Artery Disease, Stroke, Transient Ischemic Attacks (TIA), Other) (excluding varicose veins)
- Kidneys (Glomerulonephritis, Kidney Failure, Kidney Transplant, Nephritis, Nephrotic Syndrome, Polycystic Kidney Disease, Pyelonephritis, Other) (excluding kidney stones)
- Lungs / Respiratory System (Asthma, Chronic Bronchitis, Cystic Fibrosis, Sleep Apnea, Other) (excluding colds)
- Liver (Cirrhosis, Hepatitis, Other) Blood (Anemia, Leukemia, Other)
- Gastrointestinal/Digestive System (Crohn's Disease, Pancreatitis, Ulcerative Colitis, Other)
- None of the Above

HEART:

What was the diagnosis? Check **ALL** that apply.

- Congenital Heart Disease
- Heart Attack
- Valvular Heart Disease
- Coronary Artery Disease
- Heart Murmur
- Other - Please answer the questions in **Section X - Other**.

Congenital Heart Disease:

Which of the following have you ever had? Check **ALL** that apply.

- Atrial Septal Defect (ASD)
- Ebstein's Anomaly
- Tetralogy of Fallot
- Unknown
- Bicuspid Aortic Valve
- Hypoplastic Left Heart Syndrome
- Transposition of the Great Arteries
- Coarctation of the Aorta
- Patent Ductus Arteriosus (PDA)
- Tricuspid Atresia
- Dextrocardia
- Pulmonary Atresia
- Ventricular Septal Defect (VSD)
- Other - Please provide details. _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



Atrial Septal Defect (ASD):

A. Was the ASD surgically corrected?

Yes No

If **YES**, was the surgery prior to age five?

Yes No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

C. Do you have any physical limitations due to heart disease?

Yes No

D. Do you have any other heart abnormality?

Yes No

Bicuspid Aortic Valve:

A. Have you had any surgery or is surgery planned or recommended by a health care professional?

Yes No

B. Do you have any symptoms related to heart disease?

Yes No

C. Do you have any associated aortic stenosis or aortic insufficiency?

Yes No

Unknown

D. Do you have any other heart or blood vessel abnormality?

Yes No

E. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

G. Do you have any physical limitations due to heart disease?

Yes No

Dextrocardia:

A. Do you have any other heart or other congenital abnormalities?

Yes No

B. Do you have any physical limitations due to the dextrocardia?

Yes No

C. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

Patent Ductus Arteriosus (PDA):

A. Was the PDA surgically corrected before age five?

Yes No

If **NO**, did the PDA close on its own before age five?

Yes No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

C. Do you have any physical limitations due to heart disease?

Yes No

D. Do you have any other heart abnormality?

Yes No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes No

If **YES**, was the surgery prior to age five?

Yes No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

C. Do you have any physical limitations due to heart disease?

Yes No

D. Do you have any other heart abnormality?

Yes No



Heart Murmur:

Was it described as or diagnosed as: Check **ALL** that apply.

- Functional, Innocent, or a Flow Murmur
- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Atrial Septal Defect (ASD)
- Unknown
- Mitral Stenosis
- Mitral Valve Prolapse
- Mitral Insufficiency (Regurgitation)
- Pulmonary Insufficiency (Regurgitation)
- Other - Please provide details. _____
- Tricuspid Insufficiency (Regurgitation)
- Pulmonary Stenosis
- Tricuspid Stenosis
- Ventricular Septal Defect (VSD)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Functional, Innocent, or a Flow Murmur:

- A. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease? Yes No
- B. Do you have any physical limitations due to heart disease? Yes No
- C. Have you been advised to have a follow-up echocardiogram? Yes No

Atrial Septal Defect (ASD):

- A. Was the ASD surgically corrected? Yes No
- If **YES**, was the surgery prior to age five? Yes No
- If **NO**, is any surgery planned or has surgery been recommended by a health care professional? Yes No
- B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease? Yes No
- C. Do you have any physical limitations due to heart disease? Yes No
- D. Do you have any other heart abnormality? Yes No

Mitral Insufficiency (Regurgitation):

- A. Do you have any shortness of breath or limited exercise tolerance related to mitral insufficiency (regurgitation)? Yes No
- B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate? Yes No
- C. Has the mitral insufficiency (regurgitation) been described as:
 - Trivial/Slight Mild Moderate Severe Unknown
- D. Do you have any other heart abnormality including any other valvular disease? Yes No
- E. Is any surgery planned or has surgery been recommended by a health care professional? Yes No
- F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease? Yes No
- G. Do you have any physical limitations due to heart disease? Yes No
- H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years? Yes No Unknown

Mitral Valve Prolapse:

- A. Is any surgery planned or has surgery been recommended by a health care professional? Yes No
- B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse? Yes No
- C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate? Yes No



D. Do you have any mitral insufficiency (regurgitation)?

Yes No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight Mild Moderate Severe Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

F. Do you have any physical limitations due to heart disease?

Yes No

G. Do you have any other heart abnormality including any other valvular disease?

Yes No

Ventricular Septal Defect (VSD):

A. Was the VSD surgically corrected?

Yes No

If **YES**, was the surgery prior to age five?

Yes No

If **NO**, is any surgery planned or has surgery been recommended by a health care professional?

Yes No

B. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

C. Do you have any physical limitations due to heart disease?

Yes No

D. Do you have any other heart abnormality?

Yes No

Valvular Heart Disease:

Have you had valve surgery?

Yes No

Which of the following valve diseases do you have? Check **ALL** that apply.

- Aortic Stenosis
- Aortic Insufficiency (Regurgitation)
- Mitral Stenosis
- Unknown
- Mitral Insufficiency (Regurgitation)
- Mitral Valve Prolapse
- Pulmonary Stenosis
- Other - Please provide details. _____
- Pulmonary Insufficiency (Regurgitation)
- Tricuspid Stenosis
- Tricuspid Insufficiency (Regurgitation)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Mitral Insufficiency (Regurgitation):

A. Do you have any shortness of breath or limited exercise tolerance related to the mitral insufficiency (regurgitation)?

Yes No

B. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes No

C. Has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight Mild Moderate Severe Unknown

D. Do you have any other heart abnormality including any other valvular disease?

Yes No

E. Is any surgery planned or has surgery been recommended by a health care professional?

Yes No

F. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

G. Do you have any physical limitations due to heart disease?

Yes No

H. According to your health care professional has the mitral insufficiency (regurgitation) worsened in the past [three] years?

Yes No
 Unknown

Mitral Valve Prolapse:

A. Is any surgery planned or has surgery been recommended by a health care professional?

Yes No

B. Do you have any shortness of breath or limited exercise tolerance related to the mitral valve prolapse?

Yes No

C. Has a health care professional at any time told you that you have an irregular/abnormal heart rate?

Yes No



D. Do you have any mitral insufficiency (regurgitation)?

Yes No

If **YES**, has the mitral insufficiency (regurgitation) been described as:

Trivial/Slight Mild Moderate Severe Unknown

E. Has a health care professional ever recommended that you not engage in sports or other physical activities due to heart disease?

Yes No

F. Do you have any physical limitations due to heart disease?

Yes No

G. Do you have any other heart abnormality including any other valvular disease?

Yes No

ARTERIES/VEINS:

What was the diagnosis? Check **ALL** that apply.

Aneurysm Carotid Artery Disease Stroke Transient Ischemic Attacks (TIAs)
 Other - Please answer the questions in **Section X - Other**.

LUNG/RESPIRATORY SYSTEM:

What was the diagnosis? Check **ALL** that apply.

Asthma Chronic Bronchitis Cystic Fibrosis Sleep Apnea
 Other - Please answer the questions in **Section X - Other**.

Asthma:

A. Have you been hospitalized overnight for asthma in the past [24] months?

Yes No

B. Have you visited the emergency room or an urgent care center in the past [24] months related to asthma?

Yes No

If **YES**, how many times have you been to the emergency room or an urgent care center related to asthma in the past [24] months? _____

When was the last time you were in an emergency room or an urgent care center related to asthma? _____

C. Have you had asthma symptoms in the past [six] months (other than with exercise)?

Yes No

If **YES**, how often do your symptoms occur? _____ per week

D. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to asthma? _____

E. Other than inhalers, are you currently taking any medications for asthma?

Yes No

If **YES**, please list medications. _____

F. Have you taken oral steroid pills in the past [12] months for asthma?

Yes No

If **YES**, how many episodes/attacks of asthma required taking oral steroid pills in the past [12] months? _____

Were any courses of steroids longer than a continuous two week period? _____

Yes No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Chronic Bronchitis:

A. Have you been hospitalized for chronic bronchitis in the past [three] years?

Yes No

B. Do you have three or more attacks of bronchitis per year?

Yes No

C. Do you have complete recovery (no symptoms) between episodes of bronchitis?

Yes No

D. Do you have any ongoing underlying lung disease other than asthma?

Yes No

If **YES**, please provide details. _____



E. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to bronchitis? _____

F. Are you taking any medications for chronic bronchitis? Yes No

If **YES**, please list medications. _____

G. Have you required oral steroid pills in the past [12] months for bronchitis? Yes No

Unknown

If **YES**, how many episodes of bronchitis have required taking oral steroid pills in the past [12] months? _____

Were any courses of steroids longer than a continuous two week period? Yes No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Sleep Apnea:

A. What is your current treatment?

- CPAP/BIPAP Dental Appliance Surgery Weight Loss No Treatment

If **YES** to CPAP/BIPAP, have you used this for more than six months on a nightly basis? Yes No

If **YES** to Weight Loss or No Treatment, please select any other treatments that were recommended by your health care professional:

- CPAP/BIPAP Dental Appliance Surgery None

Yes No

B. Do you have any ongoing symptoms due to sleep apnea? Yes No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

KIDNEYS:

Are you on dialysis? Yes No

If **NO**, what was the diagnosis? Check **ALL** that apply.

- Glomerulonephritis Kidney Transplant Nephrotic Syndrome Pyelonephritis
 Kidney Failure Nephritis Polycystic Kidney Disease
 Other - Please answer the questions in **Section X - Other**.

Pyelonephritis:

Which of the following applies to your history of pyelonephritis: Chronic Acute Unknown

Have you had more than one episode of acute pyelonephritis? Yes No

Do you have abnormal kidney function or continuous urine abnormalities? Yes No

Are you taking any medications for pyelonephritis? Yes No

If **YES**, please list medications. _____



Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

LIVER:

What was the diagnosis? Check **ALL** that apply.

Cirrhosis Hepatitis A Hepatitis B Hepatitis C Hepatitis - Type Unknown

[If Type A, has it been more than three months since you recovered from your Hepatitis A?] Yes No

Other - Please answer the questions in **Section X - Other**.

GASTROINTESTINAL / DIGESTIVE SYSTEM:

What was the diagnosis? Check **ALL** that apply.

Crohn's Disease Pancreatitis Ulcerative Colitis

Other - Please answer the questions in **Section X - Other**.

Crohn's Disease:

A. How old were you when the Crohn's Disease was diagnosed? _____

B. Has any surgery been recommended or has surgery been planned for the next 12 months? Yes No

C. Have you ever had any surgery for Crohn's Disease? Yes No

How many surgeries? _____

If **YES**, when was the last surgery? _____

D. Other than for surgery, have you been hospitalized for Crohn's Disease in the past [three] years? Yes No

E. Do you have any complications from Crohn's Disease (strictures, obstruction, abscess, fistulas, liver disease, anemia, other)? Yes No

If **YES**, please provide details. _____

F. Have you had any weight loss due to Crohn's Disease in the past 12 months? Yes No

G. Please describe any symptoms of Crohn's Disease you have had in the past 12 months (fever, abdominal pain, diarrhea, other)? How often?

Symptom(s) _____ Frequency _____

H. Are you taking any medications for Crohn's Disease? Yes No

If **YES**, please list medications. _____

I. Have you had any changes to your medications in the past 12 months? Yes No

If **YES**, please provide details. _____

J. Have you taken oral or intravenous steroids in the past 12 months? Yes No

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



Pancreatitis:

- A. What type of pancreatitis: Acute Chronic
- B. Cause of acute pancreatitis: Gallstones Alcohol Unknown or Other
- If Gallstones:
 - Did you have your gallbladder removed? Yes No
 - If **YES**, have you had any symptoms since your gallbladder was removed? Yes No
 - If **NO**, how many episodes of acute pancreatitis have you had? _____
 - When was the last episode? _____

Ulcerative Colitis

- A. How old were you when the ulcerative colitis was diagnosed? _____
- B. Has any surgery been recommended or has surgery been planned for the next 12 months? Yes No
- C. Have you ever had any surgery for ulcerative colitis? Yes No
 - If **YES**, when was the surgery? Date _____
 - Did you have your entire colon removed (total colectomy)? Yes No
- D. Other than for surgery, have you been hospitalized for ulcerative colitis in the past [three] years? Yes No
- E. Do you know which part of your colon is diseased? Yes No
 - Which part: Rectum only (ulcerative proctitis)
 - Sigmoid and rectum
 - More extensive than just Sigmoid and Rectum
- F. Do you have any complications from ulcerative colitis (cholangitis, liver disease, anemia, other)? Yes No
 - If **YES**, please provide details. _____
- G. Have you had any weight loss due to ulcerative colitis in the past 12 months? Yes No
- H. Please describe any ulcerative colitis symptoms you have had in the past 12 months (fever, abdominal pain, diarrhea, blood in stool, other)? How often?

Symptoms _____ Frequency _____
- I. Are you taking any medications for ulcerative colitis? Yes No
 - If **YES**, please list medications. _____
- J. Have you had any changes to your medications in the past 12 months? Yes No
 - If **YES**, please provide details. _____
- K. Have you taken oral steroid pills or intravenous steroids in the past 12 months for ulcerative colitis? Yes No
- L. When was your last colonoscopy? Date _____
- M. What were the findings? (Please include any evidence of dysplasia/pre-malignancy.)

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____



BLOOD:

What was the diagnosis? Check **ALL** that apply.

- Anemia
- Leukemia
- Other - Please answer the questions in **Section X - Other**.

Anemia:

What type of anemia? Check **ALL** that apply.

- Iron Deficiency Anemia
- Sickle Cell Anemia
- Unknown
- Anemia Due to Blood Loss
- Thalassemia
- Other - Please provide details.

A. What is the source of blood loss? _____

B. Was heavy menses the source of blood loss? Yes No

If **NO**, please provide details. _____

C. How old were you when the anemia was diagnosed? _____

D. Have you ever been hospitalized due to anemia? Yes No

If **YES**, when were you hospitalized? _____

If **YES**, why were you hospitalized? _____

E. What treatment (including transfusions) have you received for anemia?

F. Are you currently receiving treatment for anemia? Yes No

If **YES**, please provide details. _____

G. Except for scheduled health care appointments, how many work or school days have you missed in the past [12] months due to anemia? _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

4. Have you ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health care professional or support group? Yes No

If **YES**, please indicate which substance you were using: Alcohol Drugs Both

Alcohol/Both:

A. Was this recommendation or counseling related to a DUI/DWI? Yes No

If **YES**, please answer the following questions.

1. Describe your current alcohol consumption:

How often do you drink alcohol? _____

How many drinks do you have on a typical day when you are drinking? _____

In the past [three] months, how often did you have more than four drinks in one day? _____

2. Describe your past alcohol consumption around the time of your DUI/DWI:

How often did you drink alcohol? _____

How many drinks did you have on a typical day when you were drinking? _____

In a typical 12 month period, how often did you have more than four drinks in one day? _____



3. Are you currently in a support group?

Yes No

If **NO**, when did you last drink alcohol? _____

Have you ever had a relapse (stopped using and then restarted using alcohol)?

Yes No

Are you currently in a support group?

Yes No

B. Have you ever had any medical complications due to drinking (liver disease, pancreatitis, other)?

Yes No

Please provide the name and address (or any other contact information) of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

5. Have you ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health care professional?

Yes No

A. Please indicate the name of the drug or drugs used. Check **ALL** that apply.

- Cocaine Marijuana Hallucinogens Barbiturates
- Heroin Narcotics Amphetamines
- Other Illicit Drugs/Controlled Substances

Please provide details. _____

MARIJUANA ONLY:

Have you used Marijuana in the past 12 months?

Yes No

If **YES**, how often do you use Marijuana per month? _____

Yes No

B. Have you ever injected these drugs?

Yes No

C. How old were you when you started using drugs? _____

D. When did you last use drugs? Date: _____

E. Have you ever sought counseling or medical attention because of your use of drugs (including hospitalization, in-patient and out-patient, rehabilitation)?

Yes No

If **YES**, what was the date of your last treatment? Date: _____

F. Have you ever had a relapse (stopped using and then restarted using drugs)?

Yes No

G. Do you drink alcohol?

Yes No

If **YES**, answer the following questions describing your current alcohol consumption.

How often do you drink alcohol? _____

How many drinks do you have on a typical day when you are drinking? _____

In the past [three] months, how often did you have more than four drinks in one day? _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

6. Have you ever been diagnosed with or treated by a health care professional for Acquired Immune Deficiency Syndrome (AIDS)?

Yes No



7. Have you ever tested positive for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus? Yes No
8. In the past [three] years, have you consulted a health care professional for a routine checkup or physical exam? Yes No
9. Other than previously disclosed, are you using any prescription medications? Yes No

If **YES**, please provide the names of all medications and the reason for each.

Names	Reason

10. Other than as indicated previously, in the past five years, have you been overnight in a hospital or other medical facility (excluding for childbirth, kidney stones, gallstones)? Yes No

If **YES**, please explain the reason for your stay and when this occurred.

Reason _____ When _____

11. Do you plan on scheduling surgery or any other medical procedure in the next [six] months that would require an overnight hospital stay (excluding for childbirth)? Yes No

If **YES**, what surgery or medical procedure and when is this scheduled?

Procedure _____ When _____

SECTION VIII - Family History

Which of the following conditions has any parent or sibling been diagnosed with **prior to age [60]**? Check **ALL** that apply.

- Prostate Cancer Ovarian Cancer Lung Cancer Congestive Heart Failure Stroke
 Breast Cancer Colon Cancer Melanoma Aneurysms Diabetes
 Heart Attack/Coronary Artery Disease (Myocardial Infarction, Angina, Other)
 None of the Above

Which of the following conditions has any parent or sibling been diagnosed with **at any age**? Check **ALL** that apply.

- Familial Colon Polyposis Huntington's Chorea Polycystic Kidney Disease
 None of the Above

Please complete the following information for each family member diagnosed with any of the above conditions.

Relationship to Proposed Insured (You)	Age if Living	Age at Death	Specific Condition(s) (list all that apply)

If Familial Colon Polyposis:

- Have you had a colonoscopy in the past three years? Yes No
 Were the results reported as normal? Yes No

SECTION IX - Military

- A. Are you a member of the military services? Yes No
- B. Are you a dependent of a member of the military services? Yes No
- C. Do you serve in any of these special forces: Navy SEALs; Air Force Special Forces; Army Rangers; Delta Force; Army Special Forces? Yes No
- D. What is your current paygrade? E1 thru E4 Higher than E4
- E. Are you being deployed abroad in the next 12 months? Yes No
 Unknown

If **YES**, please provide details (when, where, what capacity)? _____



SECTION X - Other

A. What is the disease or disorder? _____

B. How old were you when you were diagnosed with the disease or disorder? _____

C. Do you currently have this disease or disorder? Yes No

If **NO**, when was the last time that you had symptoms related to this disease or disorder? _____

D. Have you had any surgery for this disease or disorder? Yes No

If **YES**, please provide details. _____

What Surgery _____ When was the Surgery _____

E. Other than surgery, have you been hospitalized for this disease or disorder? Yes No

If **YES**: Why _____ When were you hospitalized _____

F. In the past [12] months what treatments have you received related to this disease or disorder?

G. What treatments are you currently receiving related to this disease or disorder?

H. Are you taking any medications for this disease or disorder? Yes No

If **YES**, please list medications. _____

I. Have you had any changes to your medications in the past 12 months? Yes No

If **YES**, please provide details. _____

J. Has a health care professional recommended any future surgery or procedures related to this disease or disorder? Yes No

If **YES**, please provide details. _____

K. Except for scheduled health care appointments, have you missed any time from work or school in the past [12] months related to this disease or disorder? Yes No

How much time _____ Why _____

Please provide the name and address of the health care professional who has the most complete records pertaining to this condition.

Check if this is a foreign address.

Name of Health Care Professional/Facility Name _____

Street Address _____

City _____ State/Country _____ Zip _____

Phone Number _____

Additional Information



Agreement / Disclosure

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

- My statements in this application and any amendments and supplements are the basis of any policy issued.
- This application and any amendments and supplements 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 any amendments and supplements.
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of 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 a policy is delivered to me and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) my condition of health is the same as stated in the application; and (b) I have not received any medical advice or treatment from a health care professional since the date of the application. If either (a) or (b) is not true, please contact the Company for re-evaluation of your application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I have requested a payment method of Electronic Funds Transfer from my bank account, I authorize the Company to initiate debit entries through Metropolitan Life Insurance Company to the deposit account identified in the application, using the Automatic Clearing House. This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and my Financial Institution time to act on it.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**

Fraud Warning

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.

Signatures

Signature of Proposed Insured

Date

Signed at City, State



MetLife Investors USA Insurance Company
222 Delaware Ave, Suite 900, PO Box 25130, Wilmington, DE 19899

ARKANSAS
BULLETIN 11-83

EXHIBIT A (REVISED)

CONSENT TO SUBMIT RATES AND/OR
COST BASES FOR APPROVAL

The MetLife Investors USA Insurance Company ("Company") of Delaware Does hereby
(Company Name) (City and State)
Consent and agree

- A) that all premium rates and/or cost bases both "maximum" and "current or projected," used in relation to policy form number 5E-23-12-ARCTWVWY must be filed with the Insurance Commissioner for the State of Arkansas ("Commissioner") at least sixty (60) days prior to their proposed effective date. Such rates and/or cost bases shall be deemed effective sixty (60) days after they are filed with the Commissioner, unless the Commissioner shall approve or disapprove such rates and/or cost bases prior to the expiration of sixty (60) days
- or
- B) that where the policy is a flexible or indeterminate premium whole life policy which provides for frequent changes in interest rates based on financial market conditions, the company may file a range of rates it will stay within and will notify the Department at least sixty (60) days prior to any change in the range of rates. The company must also document the method used to calculate its premium and range of rates.

MetLife Investors USA Insurance Company
(Company Name)

By Karen Johnson
(Name)

Vice President
(Title or Position)

MetLife Investors USA Insurance Company
222 Delaware Ave, Suite 900, PO Box 25130, Wilmington, DE 19899

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 A. Johnson, Vice President

8/15/2012

Date