

## ENROLLMENT AND STATEMENT OF HEALTH FORM

### GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder: <b>U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust</b>	Group Customer # <b>165928</b>
Participating Association: Tennessee ' H Q Wal Association	

### YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)		Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment	

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you?  Yes  No

**I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.**

▶ You must complete the Health Information section of this form and the enclosed Authorization for all amounts of Supplemental Life and Dependent Spouse Life Insurance.

#### Term Life and Voluntary Accidental Death and Dismemberment (VAD&D) Insurance

- Supplemental Life<sup>1</sup>  
Enter a multiple of \$10,000 \$ \_\_\_\_\_ up to \$2,000,000.
- Dependent Spouse<sup>2</sup> Life<sup>1,3</sup>  
Enter a multiple of \$10,000 \$ \_\_\_\_\_ up to \$1,000,000.
- Dependent Child Life<sup>3</sup> \$10,000

Voluntary AD&D

#### First select your option

- Member Only                       Member + Spouse/Domestic Partner<sup>1</sup>  
 Member + Child(ren)               Member + Spouse/Domestic Partner<sup>1</sup> + Child(ren)

#### Then select your level of coverage

Enter a multiple of \$10,000 \$ \_\_\_\_\_ up to \$500,000

If electing the Waiver of Premium optional provision check here:

<sup>1</sup>Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

<sup>2</sup>Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

<sup>3</sup>Amounts will be subject to state limits, if applicable.

GEF02-1

ADM

(The form number above applies to residents of all states except as follows: Form number: **GEF09-1** applies to residents of Montana; and

GEF02-1

ADM applies to residents of Connecticut, North Dakota and Utah)

#### SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.** Make a copy for your records and return to IPSCO, 6505 Lee Highway, Chattanooga, TN 37421-2420.

## Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner, please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female
_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

## Smoking Status Information

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?	Member <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse/Domestic Partner <input type="checkbox"/> Yes <input type="checkbox"/> No
If you are changing smoking status		
Status is changing from: <input type="checkbox"/> Smoker to Non-Smoker <input type="checkbox"/> Non-Smoker to Smoker	Change is for: <input type="checkbox"/> Member <input type="checkbox"/> Spouse/Domestic Partner	

GEF02-1

ADM

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**GEF02-1**

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## HEALTH INFORMATION

### SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

	Member	Spouse/Domestic Partner
1. Member's height ___ feet ___ inches		
Spouse/Domestic Partner ___ feet ___ inches		
Member's weight ___ pounds		
Spouse/Domestic Partner weight ___ pounds		
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes", indicate type: Member: _____ Spouse/Domestic Partner: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you now, or have you in the past 5 years, used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) Member: _____ Spouse/Domestic Partner: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you been <b>Hospitalized</b> as defined below (not including well-baby delivery) in the past 90 days? <b>Hospitalized</b> means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. <b>For residents of all states except CT, please answer the following question:</b> Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? <b>For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. stroke or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. cancer, Hodgkins disease, lymphoma or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. anemia, leukemia or other blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. diabetes? Member: Your age at diagnosis?: _____ <input type="checkbox"/> Check if insulin treated Spouse/Domestic Partner: Your age at diagnosis? _____ <input type="checkbox"/> Check if insulin treated	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. asthma, COPD, emphysema or other lung disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. ulcers, stomach, hepatitis or other liver disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. colitis, Crohn's, diverticulitis or other intestinal disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Member: Specify date of last seizure (month/year) _____ Indicate type _____ Spouse/Domestic Partner: Specify date of last seizure (month/year) _____ Indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. multiple sclerosis, ALS or muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. arthritis? Member: <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____ Spouse/Domestic Partner: <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

GEF09-1

HEA

(The form number above applies to residents of all states except as follows: Form number: GEF09-1 applies to residents of Montana; and

GEF09-1

HEA applies to residents of Connecticut, North Dakota and Utah)

- p. back, neck, knee, spinal, joint or other musculoskeletal disorder?
- q. carpal tunnel syndrome?
- r. kidney, urinary tract or prostate disorder?
- s. thyroid or other gland disorder?
- t. mental, anxiety, depression, attempted suicide or nervous disorder?
- u. sleep apnea?

- |                              |                             |                              |                             |
|------------------------------|-----------------------------|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**MEMBER SECTION ONLY**

**After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.**

Member Name \_\_\_\_\_ Your Date of Birth \_\_\_\_\_

**Personal Physician Information**

Personal Physician's Name: \_\_\_\_\_  
 Address (Street, City, State, Zip Code): \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Date of last visit (MM/DD/YYYY): \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**Prescription Information**

Are you currently taking any prescribed medications?  Yes  No If yes, list the medications.  
 Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_  
 Prescribing Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address (Street, City, State, Zip Code): \_\_\_\_\_  
 Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_  
 Prescribing Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Address (Street, City, State, Zip Code): \_\_\_\_\_  
 Check here if you are attaching another sheet for any additional medications.

**SECTION 2**

**Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1.** If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.  Check here if you are attaching another sheet.

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
<b>Treating Health Professional</b>		
Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: _____		

**GEF09-1**  
**HEA**  
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Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: _____		

### SPOUSE/DOMESTIC PARTNER SECTION ONLY

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

Spouse/Domestic Partner Name \_\_\_\_\_ Your Date of Birth \_\_\_\_\_

**Personal Physician Information**

Personal Physician's Name: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last visit (MM/DD/YYYY): \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**Prescription Information**

Are you currently taking any prescribed medications?  Yes  No If yes, list the medications.

Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_

Prescribing Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_

Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_

Prescribing Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_

Check here if you are attaching another sheet for any additional medications.

**GEF09-1**  
**HEA**  
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**HEA** applies to residents of Connecticut, North Dakota and Utah)

**SECTION 2**  
 Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.  Check here if you are attaching another sheet.

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.		
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment		
Treating Health Professional				
Physician's Name: _____				
Date of last visit: _____ Reason for visit: _____				
Address _____				
	Street	City	State	Zip Code
Telephone: _____				

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.		
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment		
Treating Health Professional				
Physician's Name: _____				
Date of last visit: _____ Reason for visit: _____				
Address _____				
	Street	City	State	Zip Code
Telephone: _____				

**GEF09-1**  
**HEA**  
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**FRAUD WARNINGS**

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued. **Illinois:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Tennessee: 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 a denial of insurance benefits.**

**GEF09-1**  
**FW**  
 (The form number above applies to residents of all states except as follows: Form number: **GEF09-1** applies to residents of Montana; and **GEF09-1** **FW** applies to residents of Connecticut, North Dakota and Utah)


<b>BENEFICIARY DESIGNATION FOR MEMBER INSURANCE</b>				
I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member.				
<input type="checkbox"/> Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.				
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
<b>Payment will be made in equal shares or all to the survivor unless otherwise indicated.</b>				<b>TOTAL: 100%</b>

## DECLARATIONS AND SIGNATURE(S)

### Member

By signing below, I acknowledge:


- I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
- I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
- I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
- I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
- I have read the applicable Fraud Warning(s) provided in this enrollment form.

	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
	Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

### Spouse/Domestic Partner

By signing below, I acknowledge:

- I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
- I have read the applicable Fraud Warning(s) provided in this enrollment form.

	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
	Signature of Spouse/Domestic Partner	Print Name	Date Signed (MM/DD/YYYY)

**GEF09-1**  
**DEC**  
*(The form number above applies to residents of all states except as follows: Form number: GEF09-1 applies to residents of Montana; and GEF09-1 DEC applies to residents of Connecticut, North Dakota and Utah)*

## AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:


- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.


**Note to All Health Care Providers:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Expiration, Revocation and Refusal to Sign:** This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

**By signing below, each proposed insured acknowledges his or her understanding that:**

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, your employer for a plan administration purpose, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

	Signature of Member	Date Signed (MM/DD/YYYY)
	Print Name	State of Birth

	Signature of Spouse/Domestic Partner	Date Signed (MM/DD/YYYY)
	Print Name	State of Birth