

ENROLLMENT FORM WITH HEALTH INFORMATION

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)	
Name of Policyholder: U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust	Group Customer # 165928
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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p>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.</p> <p>▶ You must complete the Health Information section of this form and the enclosed Authorization for all amounts of Supplemental Life and Dependent Spouse/Domestic Partner Life Insurance.</p>		
Term Life and Voluntary Accidental Death and Dismemberment (VAD&D) Insurance		
<input type="checkbox"/> Supplemental Life ¹ Enter a multiple of \$10,000 \$ _____ up to \$250,000 (up to age 40), \$150,000 (age 40-49) or \$100,000 (age 50-59).		
<input type="checkbox"/> Dependent Spouse/Domestic Partner ² Life ^{1,3} Enter a multiple of \$10,000 \$ _____ up to \$250,000 (up to age 40), \$150,000 (age 40-49) or \$100,000 (age 50-59).		
<input type="checkbox"/> Dependent Child Life ³ \$10,000		
<input type="checkbox"/> Voluntary AD&D First select your option <input type="checkbox"/> Member Only <input type="checkbox"/> Member + Spouse/Domestic Partner ¹ <input type="checkbox"/> Member + Child(ren) <input type="checkbox"/> Member + Spouse/Domestic Partner ¹ + 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: <input type="checkbox"/>		

¹ 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.

² 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.

³ 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 and/or Child(ren), 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

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
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If you are changing smoking status

Status is changing from: Smoker to Non-Smoker Non-Smoker to Smoker Change is for: Member Spouse/Domestic Partner

GEF02-1

ADM

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HEALTH INFORMATION

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.

Your height ___ feet ___ inches Spouse/Domestic Partner height ___ feet ___ inches
Your weight ___ pounds Spouse/Domestic Partner weight ___ pounds

	Member	Spouse/Domestic Partner
1. 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
2. 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
3. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days? Hospitalized 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
4. For residents of all states except CT, please answer the following question: 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? 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. 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, Hodgkin's disease, lymphoma or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

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

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

BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

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.


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 #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. 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.
2. 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.
3. 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.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

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

GEF09-1

DEC

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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	Country of Birth



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