

**Election of Portable Coverage Form For Group Life Insurance Coverage**

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***Important Information About MetLife's Portability Option***

You're in a time of transition, and MetLife welcomes the opportunity to provide you with an affordable option to continue the Group Life Insurance coverage that you had with your former plan.

**Here are some highlights of your Portability option...**

- **You can take coverage with you.** You may continue the same or lesser amount of life insurance coverage you had on yourself at the time of your coverage termination through your former plan (See Part A of the Election Form). The minimum amount an employee can continue on a portable basis is \$20,000; the maximum is generally equal to the Life insurance coverage amount at the time of coverage termination or \$1,000,000, whichever is less.
- **Full protection for you.** When you elect portable coverage, you will have these valuable features: MetLife's Total Control Account<sup>®</sup> (TCA) for you and Accelerated Benefits Option (ABO) for you.

**It's easy to elect Portable coverage:**

1. Complete the attached Election Form **within 31 days** from the date your benefits are terminated **or** 45 days from the date this notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated or reduced.
2. Select the portable coverage amount for you (see attached Election Form Part B).
3. Designate your beneficiary(ies) and provide the required signatures.
4. **Send your completed Election Form to: MetLife Recordkeeping Center, P. O. Box 6169, Utica, NY 13504-6169.**
5. Upon receipt of your completed Election Form, MetLife will send your initial monthly bill directly to your home address.

If you have any questions, require assistance in completing your Election Form, or wish to find out the cost of your portable coverage, you may phone our MetLife Recordkeeping Center toll-free at **1-866-492-6983**, between the hours of **8:00 a.m. and 8:00 p.m. (EST)**.

## ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is either the Employer, TPA or MetLife.)

1. Immediately upon the Insured's termination of employment, complete Part A below and make two copies of this form.
2. Provide the Eligible Insured with the original or mail it to their last known address.
3. Mail a copy of this form to MetLife Recordkeeping Center, P.O. Box 6169, Utica, NY 13504-6169.
4. Maintain a copy for your records.

### Part A – TO BE COMPLETED BY THE RECORDKEEPER

Employer Name:	Group Report No.:	Sub Division:	Branch:	Portable No.:
Insured Coverage Termination Date:	Date of This Notice:			
Insured Name: (Last, First, Initial)	Social Security Number:	Date of Birth:	Sex: (M/F)	
Insured Mailing Address: (Street, City, State, Zip)			Insured Home Telephone No.:	
Annual Salary at Coverage Termination: \$	Reason for Termination:			
Has Coverage Been Assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify coverage assigned _____ and attach a copy of assignment form. Was the insured actively at work on the date of separation? <input type="checkbox"/> Yes <input type="checkbox"/> No Recordkeeper Name: _____ Name of Person Completing Part A: _____ Telephone Number: _____				
<b>Employer To Verify Insurance Amount(s) In Effect At Termination Date:</b>				
<b>METLIFE INSURED COVERAGE AMOUNTS IN EFFECT:</b>				
<u>Life Insurance Amount</u>				
Insured: Optional Life	\$ _____			

If you are a resident of Vermont, Portable Term coverage is not available to you. If you are a resident of the state of Michigan, there is a limit to the amount of coverage you are allowed to port. For specific details about this limit, contact the MetLife Recordkeeping Center 1-866-492-6983.

MetLife provides coverage under a Group Insurance policy (Policy Number 93211-G) issued to the Chase Manhattan Bank, N.A., as Trustee. All Portable Term coverage terminates when your premium payments cease, or January 1 of the year in which you attain age 80. Portable Term insurance does not provide payment for death caused by suicide within the first two years (one year in Colorado or North Dakota) from the effective date of your coverage under your employer's Group Life Insurance benefit plan (except in Massachusetts, Missouri and Washington).

### Part B – TO BE COMPLETED BY THE INSURED

<p><b>Insured Application Period:</b> The Insured must apply for portable coverage within 31 days from the date benefits were terminated or 45 days from the date this notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated.</p>	<p>You may continue coverage at the same amount you had at the time of coverage termination or at a lesser amount. The employee minimum is \$20,000; the maximum is equal to the life insurance amount at time of coverage termination or \$1,000,000, whichever is less. At age 70, your coverage will be reduced by 50%.</p>
<b>Portable Insurance Amount(s) Requested (Please Round Coverage to the nearest thousand)</b>	
<p>Same Amount <input type="checkbox"/></p>	<p>Decreased Amount<sup>1</sup> <input type="checkbox"/></p> <p>\$ _____</p>
<p>Insured:<sup>2</sup> Optional Life <input type="checkbox"/></p>	<p>No Coverage <input type="checkbox"/></p>
NOTE: All coverage amounts are subject to applicable state laws.	

1. Specify the amount of coverage you prefer. The coverage amount selected may not exceed the coverage amount under the former plan.
2. In order to elect Portable coverage, you must have had the selected coverage under the former plan.

ENHANCED-EPORT

**Please Retain A Copy Of The Fully-Completed Form For Your  
Records And Return The Original To MetLife Recordkeeping Center  
If you have any questions, please call 1-866-492-6983**

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**ELECTION OF PORTABLE COVERAGE FORM (Continued)  
TO BE COMPLETED BY THE INSURED (Continued)**

<b>DESIGNATION OF BENEFICIARY FOR INSURED LIFE BENEFITS</b>				
<input type="checkbox"/> I Designate as my Primary Beneficiary: <input type="checkbox"/> My Designation of Beneficiary is on a separate form which is signed, dated and attached.				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
<b>TOTAL:</b>				100%
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
<b>TOTAL:</b>				100%
Unless designated otherwise, payment will be made in equal shares or all to the survivor. I RESERVE the right to change this designation at any time.				
Insured Signature: _____			Date of Signature _____ (Mo./Day/Yr.)	

**Fraud Warning:**

If you are applying for insurance under a policy issued in one of the following states, or if you reside in one of the following states, note the following applicable warning:

**New York** [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

**Massachusetts:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

**Kansas, Oregon, Washington and Vermont:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

**Puerto Rico:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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

If you are applying for insurance under a policy issued in any state other than those listed above, or if you reside in any state other than those states listed above, note the following warning:

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.**

Insured/Assignee Signature: _____	Date: _____
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**RATE SHEET**  
**Schedule of Monthly Portable Group Life Insurance Term Rates**  
**For Insured**

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age as of December 31<sup>st</sup>, of the current calendar year. Rates are subject to change.

**TABLE A**  
**LIFE INSURANCE ONLY**  
**MONTHLY TERM RATES**

AGE	INSURED RATE	AGE	INSURED RATE
15	\$0.106	48	\$0.454
16	\$0.120	49	\$0.500
17	\$0.129	50	\$0.552
18	\$0.137	51	\$0.610
19	\$0.141	52	\$0.673
20	\$0.142	53	\$0.743
21	\$0.153	54	\$0.811
22	\$0.146	55	\$0.896
23	\$0.131	56	\$0.987
24	\$0.122	57	\$1.091
25	\$0.115	58	\$1.204
26	\$0.115	59	\$1.328
27	\$0.107	60	\$1.470
28	\$0.107	61	\$1.624
29	\$0.107	62	\$1.796
30	\$0.107	63	\$1.987
31	\$0.107	64	\$2.202
32	\$0.115	65	\$2.436
33	\$0.115	66	\$2.682
34	\$0.122	67	\$2.904
35	\$0.131	68	\$3.139
36	\$0.138	69	\$3.399
37	\$0.153	70	\$3.691
38	\$0.168	71	\$4.022
39	\$0.184	72	\$4.400
40	\$0.202	73	\$4.828
41	\$0.224	74	\$5.292
42	\$0.248	75	\$5.785
43	\$0.275	76	\$6.359
44	\$0.302	77	\$6.958
45	\$0.334	78	\$7.585
46	\$0.370	79	\$8.262
47	\$0.410		

**Example Calculation of Premium For Insured Only:**

$$\frac{\$50,000}{\text{Amount of Coverage selected}} \div \$1,000 = \frac{50}{\text{\# of units}} \times \$0.334 \text{ (Rate based on Age 45)} = \$16.70 \text{ (Monthly Premium)}$$

# Privacy Notice

**If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.**

**This Privacy Notice is given to you on behalf of these companies:**

**Metropolitan Life Insurance Company**

**Paragon Life Insurance Company**

**Please read this Privacy Notice carefully.** It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

**Why We Need to Know about You:** We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But depending on the type of product or insurance, we may need more information. This may include information about your finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies. Our affiliates currently include car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

**How We Learn about You:** What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about your finances, employment, hobbies, mode of living, work history, and driving record.

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at [www.mib.com](http://www.mib.com).

**How We Protect What We Know About You:** We take steps we consider reasonable to make sure that what we know about you is treated confidentially. For example, our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

**How You Can See and Correct Your Information:** Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If the law allows us to do so, we may disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

**You Can Get Other Material from Us:** In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, [www.metlife.com](http://www.metlife.com), or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you are writing about.