

Metropolitan Life Insurance Company

Statement of Health For Enrollment For Employee or Dependent Group Insurance

Instructions for Completing Statement of Health Form SOH2000

A separate Statement of Health form is required for each applicant requesting insurance.

Information to be Completed by Employee

- Complete SOH Reporting Location (if applicable)
- Complete Employee Name, Social Security Number **
- Select Type of Insurance. If Life Insurance, enter the additional amount of insurance
- Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Information to be Completed by Applicant

The applicant must complete all information located in the boxes at the top:

- Relationship of Applicant to Employee, Applicant Name, Sex, Date of Birth
- Address
- Business and Home Telephone Number, E-mail Address, State of Birth, Country of Birth

Medical Information — must be completed.

- Complete Question 1.
- Check "Yes" or "No" for Questions 2–6 (all parts).
- Complete Question 7.
- Complete the details section at the bottom of the first page if any of the questions 2-6 were answered "Yes."

The employee must always sign and date his/her form.

Any dependent over 18 years of age requesting insurance must sign and date his/her form.

Upon completion of the Applicant Information, detach the Consumer Privacy Notice and retain for your records. Make a copy of the completed form for your records and return the completed 2-page form to your employer.

NOTE to Employer:

Please mail fully completed forms to:

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 6081
Utica, NY 13504-6081

For inquiries, contact 1-800-638-6420, prompt 1 (Statement of Health Unit).



STATEMENT OF HEALTH FOR ENROLLMENT FOR EMPLOYEE OR DEPENDENT GROUP INSURANCE

To be Completed by the Employee

Form with fields for Employer Name (Augusta State University), Customer Number (94171), Reporting Location Number, Employer's Mailing Address (2500 Walton Way), City (Augusta), State (GA), Zip Code (30904), Employee Name (First, MI, Last), and Social Security Number (Must Complete). Includes insurance requested options and enrollment year.

To be Completed by the Applicant (A separate form must be completed for each Applicant)

Form with fields for Insurance is for (Employee, Spouse, Child), Applicant Name (First, MI, Last), Sex (Male, Female), Date of Birth (Mo, Day, Yr), Mailing Address, City, State, Zip Code, Business Phone Number, Home Phone Number, E-mail Address, State of Birth, and Country of Birth.

Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the person for whom insurance is requested.

- 1. Height ___ feet ___ inches Weight ___ lbs
2. Are you now: a. pregnant? b. taking prescribed medications... c. receiving or applying for any disability benefits...
3. In the past 5 years, have you received medical treatment or counseling...
4. In the past 3 years, have you been convicted of driving while intoxicated...
5. Have you ever been diagnosed, treated, tested or given medical advice by a physician or other health care provider for: a. chest pain or heart trouble? b. high blood pressure... g. ulcers, stomach or liver disorder?
6. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)...
7. Personal Physician: _____ Date and reason for last visit: _____ Address: _____ Phone Number: _____

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Table with 5 columns: Question Number, Dates of Treatment, Diagnosis/Condition, Duration, Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code.

Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Authorization To Collect and Disclose Information — for underwriting and claim purposes, I **permit**: any physician, hospital, clinic, other medical related facility, employers and group policyholders, contractholders or benefit plan administrators:

To disclose to Metropolitan Life Insurance Company ("MetLife") and any benefit plan administrators, consumer reporting agencies, the Medical Information Bureau, Inc. (MIB), attorneys, and independent claim administrators acting on MetLife's behalf, any and all medical data that you may have on the person proposed for insurance. I specifically authorize disclosure of findings on: medical care or surgery; psychiatric or psychological care or examinations; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable diseases may be controlled by various laws and regulations. I consent to disclosure of such information to MetLife but only in accordance with laws and regulations as apply to me. MetLife may collect, use and re-disclose any information in its possession, including medical information, as indicated in the Consumer Privacy Notice which accompanies this form.** I understand that I may revoke this authorization at any time. If I do not, it will be valid for the lesser of: 24 months from the date I sign it, the term of insurance under the policy or the duration of a claim. A photocopy of this authorization is as valid as the original form. You or your authorized representative have a right to receive a copy of this authorization on request.

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.

Kansas and 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.

Oregon: 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.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

If you are applying for coverage under a self-funded plan or 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 is a crime and subjects such person to criminal and civil penalties.

(Employee must always sign)	
Signed _____	Date _____
(Person for whom insurance is being requested if other than Employee and at least 18 years of age)	
Signed _____	Date _____



Metropolitan Life Insurance Company
Consumer Privacy Notice

Thank you for requesting insurance from Metropolitan Life Insurance Company ("MetLife"). This notice refers to MetLife as "we," "us," or "our." We will evaluate your request for insurance (enrollment form and, if applicable, statement of health form) to see if you and any other person proposed for insurance (each referred to as "you" or "your") are eligible for the insurance requested. We review all the information provided in your request for insurance and we may then confirm or add to this information in ways explained below. MetLife and each member of the MetLife family of companies (each an "Affiliate") strongly believe in protecting the security and confidentiality of information we collect about you. This notice describes our privacy policy and how we treat the information we collect about you ("Information").

Consumer Privacy Notice

Why We Collect and How We Use Information: We collect and use Information for purposes of our insurance and other business relationships with you. These business purposes include evaluating a request for our insurance or other products or services, evaluating benefit claims, administering our products or services, and processing transactions requested by you. We may also use Information to offer you other products or services we provide.

How We Collect Information: If we need to verify or obtain additional Information in connection with a request for our products or services or a claim for benefits, we may do so through third parties such as adult family members, employers, other insurers, consumer reporting agencies, physicians, hospitals and other medical personnel. Information collected may relate to your finances, employment, health, avocations or other personal characteristics, as well as to transactions with us or with others, including our Affiliates. If we required you to sign an authorization to collect and disclose information ("Authorization") in connection with your request for insurance, we may also obtain Information about you in accordance with the signed Authorization. For instance, we may:

- ask you to have a medical evaluation; or
- ask physicians, hospitals, or other medical care providers to confirm or add to the medical data you have given us.

How We Protect Information: We treat Information in a confidential manner. Our employees are required to protect the confidentiality of Information. Employees may access Information only when there is an appropriate reason to do so, such as to administer or offer our products or services. We also maintain physical, electronic and procedural safeguards to protect Information. These safeguards comply with all applicable laws. Employees are required to comply with our established policies.

Information Disclosure: We may disclose any Information when we believe it necessary for the conduct of our business, or where disclosure is required by law. For example, Information may be disclosed to others to enable them to provide business services for us, such as helping us to evaluate requests for insurance or benefits, and assisting us in processing a transaction requested by you. Information may also be disclosed for audit or research purposes; or to law enforcement and regulatory agencies, for example, to help us prevent fraud. Information may be disclosed to Affiliates as well as to others that are outside of the MetLife family of companies, such as companies that process data for us, companies that provide general administrative services for us, other insurers, and consumer reporting agencies. Our Affiliates include financial services companies such as life and property and casualty insurers, securities firms, broker dealers and financial advisors and may also include companies that are not financial services companies. We may make other disclosures of Information as permitted by law.

Information may be shared with our Affiliates so that they may offer you products or services from the MetLife family of companies. We may also provide Information to others outside of the MetLife family of companies such as (i) companies we engage to assist us in offering our products and services to you, and (ii) financial services companies with which we have a joint marketing agreement, for example, an agreement with another insurer to enable us to offer certain of that insurer's products. If we enter into such a joint

marketing agreement, the agreement will provide for the protection of the confidentiality of your Information. We do not make any other disclosures of Information to other companies who may want to sell their products or services to you. For example, we will not sell your name and address to a catalogue company. We may disclose any Information, other than a consumer report or health Information, for the purposes described in this paragraph.

Access to and Correction of Information: Generally, upon your written request to us, we will make Information available for your review. Medical Information will generally be disclosed through the licensed physician you choose or as otherwise required by law. Information collected in connection with, or in anticipation of, any claim or legal proceeding will not be made available. If you notify us that any of the Information is incorrect, we will review it. If we agree, we will correct our records. If we do not agree, you may submit a short statement of dispute, which we will include in any future disclosure of Information.

Consumer Reports: It is common for an insurance company to ask a consumer reporting agency to confirm and add to the Information provided in a request for insurance. Such agencies are independent and impartial. Consumer reports may reflect your mode of living, character, general reputation, personal characteristics, credit worthiness and credit standing. Information on your past and present employment, job duties, driving record, health history, use of alcohol and drugs, finances, hazardous sport activities, and marital status may be included, as well as other Information. The Information we get will be used only for business purposes related to the insurance you have requested. The Information may be kept by the agency and later given to others as permitted by the Federal Fair Credit Reporting Act and any applicable state law.

Upon your request, we will tell you whether we requested a consumer report in connection with your request for insurance. If such a report was requested, we will provide you with the name, address and telephone number of the consumer reporting agency that provided the report to us. You may contact that agency to inspect or obtain a copy of that report.

The Medical Information Bureau, Inc. (MIB) is one such consumer reporting agency. It is a nonprofit organization of life insurance companies and operates an information exchange for its members. If you apply to some other member company for life or health coverage, or send in a claim for benefits, MIB may, upon request, supply that company with any information in its file. We, or our reinsurers, may make brief reports of certain medical and non-medical information to MIB on any person for whom coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask it to correct the information as provided in the Federal Fair Credit Reporting Act. You can write to MIB, Inc., Post Office Box 105, Essex Station, Boston, MA 02112 or call (617) 426-3660.

This notice is required by law.

Further Information: This notice is a general description of MetLife's information practices. We treat Information in accordance with all applicable laws. Such laws may provide you with additional rights. For additional information regarding our privacy policy, you may write to MetLife, P.O. Box 2006, Aurora, Illinois, 60507-2006.