

Group Universal Life (GUL) Program
Change Form



Group Name Clackamas County GUL# 74414

Work Location (City, State, Zip) 2051 Kaen Rd, Suite 310, Oregon City, Oregon, 97045

Employee Social Security # _____ Daytime/Work Phone # _____

Last Name _____ First _____ M.I. _____ Date of Birth _____

Street Address _____ Apt.# _____

City _____ State _____ Zip Code _____

Please check box if the information above represents a change of address.

1 EMPLOYEE COVERAGE: Cancel Coverage **or** (Increase* Decrease) the face amount of insurance.

Your choice of coverage is \$10,000 to a maximum of \$300,000, in \$10,000 increments. Face Amount Chosen \$ _____

Monthly Cash Contribution to the GUL Fund: Cancel Fund Only **or** (Increase Decrease) monthly contribution
from _____ to \$10 \$15 \$25 Other \$ _____

Previous Monthly Employee Premium \$ _____ **New Monthly Employee Premium \$** _____
(call 1 800 GET-MET 8) toll-free to verify premium)

Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 1 year from the date of this change form? Yes No

* If you are increasing your coverage amount, include proof of your family status change within 31 days of the event, or complete Sections 5 & 6 on the following page and complete and submit a Statement of Health form.

X _____ Date _____
Signature of Employee, or Owner if Coverage was Assigned

2 SPOUSE COVERAGE: Add* Drop Increase* Decrease

Note: Spouse coverage amount may not exceed the employee coverage amount under this program.

Spouse Name _____ Social Security # _____ Date of Birth _____

Coverage Amount: Please choose an amount between \$10,000 to \$300,000, in \$10,000 increments.

Previous Monthly Spouse Premium: \$ _____ **New Monthly Spouse Premium: \$** _____

Has the Dependent Spouse smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 1 year from the date of this change form? Yes No

* If you are increasing or adding coverage for a spouse who was previously eligible, please complete Sections 5 & 6 on the following page and complete and submit a Statement of Health form.

X _____ Date _____
Signature of Employee, or Owner if Coverage was Assigned

3 CHILD(REN) COVERAGE: Add Drop Increase Decrease

Coverage Amount: \$2,000 \$4,000 \$6,000 \$8,000 \$10,000

X _____ Date _____
Signature of Employee, or Owner if Coverage was Assigned

4 CHANGE SMOKING STATUS: From smoker to non-smoker* From non-smoker to smoker

Covered person _____ Social Security # _____

* You are a non-smoker if you have not smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 1 year.

X _____ Date _____
Signature of Employee, or Owner if Coverage was Assigned

I declare that the Covered Person is / is not currently smoking, and has / has not smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within the preceding 1 years.

5

MEDICAL INFORMATION: Complete all questions below if: (a) you are increasing your employee coverage amount up to \$500,000; (b) you are increasing dependent coverage; or (c) you are enrolling for spouse coverage that exceeds \$20,000 up to \$50,000.

If you are increasing your coverage in an amount between \$500,000 and \$300,000, or you are increasing more than one salary level or your spouse is enrolling for a coverage amount, or increasing coverage, between \$50,000 and \$100,000, you must complete a Statement of Health form for each person to be covered. If you are adding coverage for dependents who were previously eligible but not enrolled, you must complete a Statement of Health form for each person to be covered. Your coverage will be limited to the non-medical issue amount until you receive notice that MetLife has approved your request for greater amounts of coverage.

	Employee	Spouse
A. Have you been Hospitalized (as defined on page 3 of this form) during the 90 days preceding the date of this enrollment form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) High blood pressure, stroke or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Cancer or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Anemia, leukemia or other blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immune Deficiency Virus (HIV) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. 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
E. On the date of enrollment form are you receiving or applying for any disability benefits, other than medical expense benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Employee: Height _____ Weight _____		
Spouse: Height _____ Weight _____		

If you answered "Yes" to any of the above questions for you or any of your dependent(s), you must also complete and attach a Statement of Health for that individual. MetLife will review your answers to the above questions and any additional information you provide regarding the health status of the person for whom coverage is being requested, as of the date MetLife receives the completed Change Form. Any decision to issue coverage will not take into account any material change in the health status of the person for whom coverage is being requested which occurs after the date we receive this Change Form.

6 AUTHORIZATION SECTION

TO BE COMPLETED BY THE EMPLOYEE AND OTHER PROPOSED INSURED(S) AGE 18 YEARS OR OLDER

Authorization to Collect and Disclose Information - for underwriting and claim purposes, I permit: any physician or other medical practitioner, 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, 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 24 months from the date I sign it. A photo copy of this authorization is as valid as the original form. I also understand that I or my authorized representative have a right to receive a copy of this authorization on request.

DECLARATION SECTION--Each Proposed Insured signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each Proposed Insured understands that this information will be used by MetLife to determine his or her insurability.

For the Employee Proposed Insured:

I **declare** that I am actively at work on the date of this enrollment form and, for any contributory life insurance only, I have been actively at work for at least 20 hours during the 7 calendar days preceding that date. I **understand** that if I am not so actively at work on the Effective Date of my contributory life insurance only, such insurance will not take effect until MetLife receives evidence of my good health satisfactory to MetLife. I **also understand** that if I have been Hospitalized (as defined below) during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of my good health satisfactory to MetLife.

For the Dependent Proposed Insured(s):

I understand that, on the date a dependent insurance benefit is scheduled to take effect, I must not be: confined at home under a physician's care; receiving or applying for disability benefits from any source; or Hospitalized. If I do not meet this requirement on such date, my insurance will take effect on the date I am no longer: confined; receiving or applying for disability benefits from any source; or Hospitalized.

Hospitalized means: admission for inpatient care in a hospital; receipt of care in the following: a hospice facility; an intermediate care facility; or a long term care facility; or receipt of the following treatment, wherever performed: chemotherapy; radiation therapy; or dialysis.

For the Accelerated Benefits Option

I **understand** that my Life Benefit includes an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. I **also understand** that receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

For Benefit Increases Requested After Initial Enrollment Period Expires

I **understand** that if I have not elected the maximum life benefits for which I or my dependent(s) are eligible, I or my dependent(s) may be required to submit evidence of good health satisfactory to MetLife if I want to increase such benefits after my initial enrollment period has expired. I **also understand** that coverage will not take effect, or it will be limited, until I receive notice that MetLife has approved the benefit increase.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

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 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.

Signature(s):

The employee must sign in all cases.

Employee Signature

Date (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature

Print Name

Date (Mo./Day/Yr.)

Other Signature

Print Name

Date (Mo./Day/Yr.)

If you have any questions, please contact one of our Customer Service Representatives toll-free at

1 800 GET-MET 8

Please send this completed form to:

**MetLife
Group Life Products
P.O. Box 2006
Aurora, IL 60507-2006**

PRIVACY NOTICE

If you submit a request for insurance (enrollment form, and if applicable, Statement of Health 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 each of these companies:

Metropolitan Life Insurance Company

Paragon Life Insurance Company

Please read this Privacy Notice carefully. It describes how we learn about you and how we treat that information. (If anyone else is proposed for insurance, what we say here also applies to information about them.)

Why We Need Information: 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 it to administer your business with us, evaluate claims, process transactions and run our business. And we 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 we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "affiliates") or with other companies.

How We Get Information: 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 (617) 426-3660, or by contacting MIB at www.mib.com.

How We Protect What We Know: We treat what we know about you confidentially. 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 take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use what 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 and other crimes
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

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 policy

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 disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise, we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, to you.

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.) Also, if the law allows us to do so, we may decide to 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 in any future disclosure of Information.

You Can Get Other Material from Us: This is a general description of our information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to us at MetLife, c/o MetLife Privacy Office, P.O. Box 2006 Aurora, Illinois 60507-2006.