MBA Civilian Life

FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES

MILITARY BENEFIT ASSOCIATION

Underwritten by Metropolitan Life Insurance Company (MetLife)

Welcome to Military Benefit Association (MBA)

We are a nonprofit organization of military personnel and civilian employees of the United States Government and their spouses.

We offer our Members an attractive package of insurance and other benefits.

Established in 1956, MBA is one of the oldest and largest associations of its kind.

ELIGIBILITY

You are eligible if on your coverage effective date you are under age 70, a citizen of the United States and a full-time civilian employee of the United States Government on a regular and continuing basis.

FEATURES

Continuous Coverage to Age 90 (Coverage amount reduces at ages 70 and 80. See Benefit Provisions and Schedules.) 24 hours a day, anywhere in the world, during times of war and peace.

Emergency Death Benefit

An advance payment of up to $10,000 may be paid promptly to the designated beneficiary on the death of a Member upon request and verification.

Accelerated Benefits Option[1]

For access to funds during a difficult time

You can receive up to 80% of your Term Life insurance proceeds to a maximum of $500,000 in the event that you become terminally ill and are diagnosed with less than 12 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time.

Competitive monthly premiums

Insured Members qualify for non tobacco discount if they have not used tobacco products during the past 12 months.

Member Monthly Premium Per $50,000 Unit of Coverage (Maximum Coverage up to $500,000)		
Member's Attained Age	Non Tobacco User Premium	Tobacco User Premium
0-29	$ 2.50	$ 5.00
30-34	2.90	5.80
35-39	3.10	6.20
40-44	4.00	8.00
45-49	5.00	10.00
50-54	8.50	17.00
55-59	15.50	31.00
60-64	23.79	47.58
65-69	45.78	91.56
70-74*	74.26	148.51
75-79*	120.40	240.79
80-84*	195.01	390.03
85-89*	315.77	631.54

How to Calculate Your Premium

Find the monthly premium for your age using the Member Premium table above, and multiply the monthly premium by the number of $50,000 units of coverage you desire. up to $500,000.

**Note: When you reach age 70, your coverage will reduce to 35% of what it was on the day it was prior to you turning 70. Your premium amount will be adjusted to reflect your reduced amount of coverage. Additionally, when you turn 80, your coverage will reduce to 10% of what it was on the day it was prior to you turning 70. Your premium amount will be adjusted to reflect your reduced amount of coverage.*

Premium Rates

Rates are based on your current age on your effective date of coverage. Rates will change when you move into a higher age band or may change at anytime if the entire Group's rates are changed. An increase in your allotment or premium payment will be necessary if one of these events occurs. If you fail to pay the increase in premium, your coverage will be continued, but at a reduced amount.

Benefit provisions and schedules

Member's Death Benefit			
Number of $50,000 Units	Age at death 0-69	Age at death 70-79	Age at death 80-89
1	$50,000	$17,500	$5,000
2	$100,000	$35,000	$10,000
3	$150,000	$52,500	$15,000
4	$200,000	$70,000	$20,000
5	$250,000	$87,500	$25,000
6	$300,000	$105,000	$30,000
7	$350,000	$122,500	$35,000
8	$400,000	$140,000	$40,000
9	$450,000	$157,500	$45,000
10	$500,000	$175,000	$50,000

Note: The Lump Sum Death Benefits listed above assume that the Member pays the premium increases scheduled at each new age bracket; otherwise, the Lump Sum Death Benefit will be reduced to 90% of the amounts the premium actually paid provides at the Member's age. You may request an example from MBA.

All insurance on a Member insured under this coverage will terminate on the premium due date which coincides with, or next follows, his or her 90th birthday.

Effective Date of Insurance

Coverage becomes effective on the first day of the month coincident with or next following both a) approval of your application for insurance and b) receipt by MBA of the required premium. Please note that your scheduled effective date will be impacted if, on that day, an illness prevents you from completing a day of regular employment or from performing your normal activities. Normal activities means that you are not confined to a hospital, or at home under the care of a physician for any medical reason. Also, if a dependent child is hospitalized on the date his or her insurance would otherwise go into effect, the coverage will not begin until the day after he or she is discharged.

Conversion Privilege

Members and dependents have a conversion privilege, upon the the occurrence of certain events, including termination of group coverage at age 90, to an individual policy of life insurance with MetLife, as explained in the certificate of coverage.

Exclusion

No benefit will be paid if a Member's or dependent's death occurs from suicide in the first two years of coverage, or if health is misrepresented. Instead, the premium will be refunded.

Cancellation Protection, Termination

Life insurance coverage cannot be terminated by the insurer prior to age 90 for the Member and for the dependent spouse, as long as MBA membership continues, the master group policy stays in force, premiums continue to be paid, and the above exclusions do not apply. Child coverage terminates on the date the child marries, reaches age 21 (age 25 if enrolled as a full-time student in an accredited school), or when Member ceases to be insured, if earlier.

How to apply

Complete the Application Form

Requests for membership and insurance must be approved by MBA and MetLife. Be sure to complete the Enrollment Application Form, front and back. Additional evidence of insurability and/or a medical examination may be required. The maximum coverage available on any one individual under any combination of life insurance coverage through MBA with MetLife is $500,000.

Return the Application Form

You must meet eligibility for membership requirements on the effective date of insurance coverage. Therefore, application forms must be approved and payment of the first month's premium must be received while you are still eligible. Application forms should be received at least three months before determination of eligibility. If immediate life insurance coverage is desired upon approval of the application form, you must enclose a check or money order payable to MBA for three months premium. If monthly premiums are to be paid by Electronic Funds Transfer (EFT) from your bank or credit union, please complete and enclose the EFT Authorization form and include a voided check with the enrollment application form. If premium is to be paid by credit card, please complete and enclose the Credit Card Authorization Form. If EFT or credit card is not available to you, a check or money order for your premiums for three months must be included with the enrollment application form. You will be billed quarterly or semi-annually for future premiums.

Tear out and complete the application in this booklet.
Then send to Military Benefit Association in the enclosed postage-paid envelope.

Coverage will either be approved by MetLife based upon its underwriting rules and your answers or you will be asked to submit additional medical information in order for MetLife to complete its review of your application for coverage. Coverage is not available in all states and certain state limitations may apply to some provisions. All applications are subject to review and approval by Metropolitan Life Insurance Company based upon its underwriting rules. This policy contains certain exclusions, limitations, reductions of benefits and terms for coverage. Any such exclusions, reductions or limitations will be fully described in the life insurance certificate, the terms of which shall govern the provision of benefits. You may also call MBA at phone 1-800-336-0100 for additional information.

When you attain age 70, your life insurance will be reduced to 35% of the amount of life insurance in force on the day before you attained 70, when you attain age 80, your life insurance will be reduced to 10% of the amount of life insurance in force on the day before you attained age 80.

[1] The Accelerated Benefits Option is subject to state regulation and is intended to qualify for favorable tax treatment, in which case the benefits will be excludable from income and not subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits may have on public assistance eligibility for you, your spouse or your family.

MBA Military Benefit Association

MetLife
Metropolitan Life Insurance Company, New York, NY

TERM 90 PLUS ENROLLMENT FOR U.S. GOVERNMENT CIVILIAN EMPLOYEES (ASSOCIATE MEMBER) • CHANGE FORM

SECTION 1 – Your Enrollment Information (To be Completed by the Associate Member)

Associate Member's Name (First, Middle, Last)	Associate Member's SSN # – –	Date of Birth (MM/DD/YYYY)
☐ Male ☐ Female	☐ Married ☐ Single ☐ Widowed ☐ Divorced	
Current Mailing Address (Street, City, State, Zip Code)		
Permanent Home Address (Street, City, State, Zip Code)		
Home/Cell Phone #	Work Phone #	Email Address

SECTION 2 – Associate Member Status

Are You a U.S. Citizen? ☐ Yes ☐ No

Are You working on a full time basis for the U.S. government? ☐ Yes ☐ No

SECTION 3 – Coverage Selection

Select one: ☐ New Member ☐ Current Member Requesting Additional Coverage ☐ Current Member Requesting Change in Coverage

I have read my enrollment materials and request the following coverage as indicated below. I understand that contributions are required for the benefits I select below.

☐ **Associate Member Term 90 Plus Life Insurance**[1]

☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000 ☐ $450,000 ☐ $500,000

Note: If you are requesting $100,000 or more of Term 90 Plus Life Insurance, the cost of Dependent Child Term 90 Plus Life Insurance [2] is included.For every $50,000 of member coverage elected by you over $100,000, the amount of Dependent Child coverage will increase in multiples of up to $2,500 with a maximum of up to $12,500.

Is this insurance coverage intended to replace any existing life insurance or annuity contracts currently held by you (except for current MBA Term Life Insurance)?
☐ Yes ☐ No

[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] Amounts will be subject to state limits, if applicable.

SECTION 4 – Dependent Information

CHILD(REN)
Names(s) of your Child(ren) (Provide the additional information on a separate piece of paper and return it with your enrollment form.)

First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	
First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
First Name	MI	Last Name	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

SECTION 5 – Tobacco Use

Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No

FOR INTERNAL USE ONLY – Group Customer Information to be completed by the Recordkeeper

Name of Group Customer/Association	Group Customer #	Experience #	Report #	Sub Code
Military Benefit Association (MBA)	**0149107**			

Date of Membership (MM/DD/YYYY)	Member ID #	Coverage Effective Date (MM/DD/YYYY)

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SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.** Make a copy for your records and return the original to MILITARY BENEFIT ASSOCIATION, 14605 Avion Parkway, P.O. Box 221110, Chantilly, VA 20153-1110 or fax to (703) 968-6423.
Call 1-800-336-0100 or visit www.militarybenefit.org

Initial _____ SSN# (Last 4) _____

SECTION 6 – 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.

Height _____ feet _____ inches Weight _____ pounds

1. Personal Physician's Name: _____

Date of last visit (MM/DD/YYYY): _____

Reason for visit: _____

Address _____ Telephone: (_____) _____
STREET CITY STATE ZIP CODE

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

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____

Address _____ Telephone: (_____) _____
STREET CITY STATE ZIP CODE

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

For questions 3 through 7, for "yes" answers, please provide full details in the section below.	**ASSOCIATE MEMBER**
3. 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?	☐ Yes ☐ No
4. Are you now receiving or applying for any disability benefits?	☐ Yes ☐ No
5. 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) _____	☐ Yes ☐ No
6. 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?	☐ Yes ☐ No
7. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: cardiac or cardiovascular disorder; stroke or circulatory disorder; high blood pressure; cancer; blood disorder; diabetes; lung disease; liver or intestinal disorder; mental illness, anxiety, depression, attempted suicide or nervous disorder?	☐ Yes ☐ No

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For questions 8 and 9, for "yes" answers, please provide full details in the section below.	**ASSOCIATE MEMBER**
8. In the past 5 years, have you been **Hospitalized** as defined below (not including well-baby delivery)? **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.	☐ Yes ☐ No
9. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for any other medical condition or had a surgical procedure (other than oral surgery)?	☐ Yes ☐ No

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Associate Member

Please provide full details below for each "Yes" answer to questions 3 through 9. 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.

Question Number(s)	Condition/Diagnosis	Please list any medication prescribed that is not already identified in Section 6 Question 2
Date of Diagnosis (MM/YYYY)	**Date of Last Treatment (MM/YYYY)**	**Type of Treatment**

Treating Health Professional

Physician's Name: _____

Date of last visit: _____

Reason for visit: _____

Address _____ Telephone: (_____) _____
STREET CITY STATE ZIP CODE

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SECTION 7 – 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.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company 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 Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: 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.

Maine, Tennessee and Washington: 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.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): 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 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.

Oklahoma: WARNING: 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

Pennsylvania and all other states: 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.

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SECTION 8 – Beneficiary Designation for Associate Member Insurance

Note: Dependent insurance is payable to the Associate Member.

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 and attach a separate page. Include all beneficiary information, and sign/date the page.

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%**
If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):				
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%**

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DEC

SECTION 9 – 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 my insurability.
2. I declare that I have completed a day of regular employment or normal activities on the date I am enrolling. I understand that if I have not completed a day of regular employment or normal activities on the scheduled effective date of insurance, such insurance will not take effect until the day after completion of the next day of normal 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 Associate Member	Print Name	Date Signed (MM/DD/YYYY)

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Initial _____ SSN# (Last 4) _____

PAYMENT INFORMATION

☐ Electronic Funds Transfer (complete the EFT section of the Additional Forms and Information sheet)

☐ Credit/debit card authorization for automatic payment. (complete the Credit Card Authorization form)

☐ Check/Money Order for the first three (3) months. DO NOT SEND CASH. Coverage will be effective on the first of the following month, after MetLife approval and receipt of required contributions.

☐ For immediate coverage (effective after MetLife approval and receipt of required contributions) enclose a check/money order for the first three (3) months. DO NOT SEND CASH

FIELD UNDERWRITER SECTION

I HEREBY CERTIFY that the answers given to the foregoing questions on this application are full, complete and true to the best of my knowledge and belief; that I know of no condition affecting the insurability of any person proposed for insurance which is not fully set forth herein; that I carefully asked each question as written before recording each answer prior to the application being signed; that the Special Notice regarding Information Practices and the Federal Fair Credit were given to the proposed insured.

To the best of your knowledge, is this insurance coverage intended to replace any existing life insurance or annuity contracts currently held by you (except for except current MBA Term Life Insurance, Servicemembers Group Life Insurance (SGLI) and Veteran's Group Life Insurance (VGLI))? ☐ Yes ☐ No

If either answer is "Yes", you must attach completed replacement form(s) required by your state.

Name of Field Underwriter (First, Middle, Last)	Field Underwriter Code #	Agency/Marketing Director Code #	Agency Phone #
			(_____) _____

Signature of Field Underwriter	Date Signed (MM/DD/YYYY)

COMPLETE FOR EFT AUTHORIZATION ONLY

I hereby authorize Military Benefit Association to initiate on or after the fifth day of each month debit entries to my checking account indicated below and on the attached voided check, and I hereby authorize the depository institution named below to debit the same from my account. Said debits shall be for the amount(s) of my monthly premium payments at the regular rates applicable to these premiums. It is understood that the amounts of these debits will be adjusted by MBA in accordance with any applicable premium increases or decreases.

My premium is due and payable on the first of each month. I agree to have two months premium deducted for my first EFT payment if I have not enclosed an initial payment with my application. I further agree that if any such debit should be dishonored, whether with or without cause and whether intentionally or unintentionally, MBA and the depository institution shall be under no liability whatsoever even if termination of insurance results.

This agreement is to remain in full force and effect until MBA has terminated it upon 60 days notice to me, or received notification from me of its termination in such time and manner as to afford MBA a reasonable opportunity to act on it.

Name and address of Bank, Savings & Loan, Credit Union, etc., where you have a personal checking account. (Attach a voided check.)

Routing/Transit Number (First 9 digits from the lower left corner of your personal check).
If your checking account is through a Credit Union, please contact them for the number.

Checking Account No. | Member's Name (Please Print) | Member's Social Security No.

Please deduct my EFT Payments for: ☐ Life Premium

Signature (as it appears on depository records)

IMPORTANT: Remember to attach a voided check to this authorization.

COMPLETE FOR CREDIT CARD AUTHORIZATION ONLY

I Member/Applicant Name as it appears on card (please print) | Member MIN/SSN

Billing Address | Personal Email Address

City | State | Zip | Home Phone Number

I authorize Military Benefit Association to charge my:

Select type of card: ☐ VISA ☐ Master Card ☐ Discover | Alt / Cell Number

Card Number | Expiration Date ___/___/___

Select One Payment Option (see Premium table to compute payment amount):

Quarterly Payment $ (Monthly Premium X 3) ☐

Semi-Annual Payment $ (Monthly Premium X 6) ☐

Annual Payment $ (Monthly Premium X 12) ☐

Please charge my card automatically for recurring payments. ☐ Yes ☐ No
(You will not be billed for future payments, they will be deducted automatically)

I request immediate coverage FOLLOWING APPROVAL and authorize the first deduction on that date. ☐ Yes ☐ No

Signature | Date

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 /or 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, 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.

Sign Here

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

Print Name _____

AUTH-MBA (11/16)

Applicant Check List

- ☐ Have you answered the Tobacco Use question in Section 5?
- ☐ Have you answered all the health questions in Section 6 and provided additional information where needed?
- ☐ Have you signed your name in both Section 9 and above?
- ☐ Have you selected a payment method in the Payment Information section?

Thank you for your application for Life Insurance with Military Benefit Association.

MetLife

OUR PRIVACY NOTICE

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- 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:

- Reputation
- Work and work history
- Driving record
- Hobbies and dangerous activities
- Finances

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 that 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., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
MetLife Insurance Company USA
SafeGuard Health Plans, Inc.
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

MILITARY BENEFIT ASSOCIATION
14605 Avion Parkway, P.O. Box 221110
Chantilly, VA 20153-1110
1-800-336-0100
http://www.militarybenefit.org

MetLife

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166
www.metlife.com