10-Year And 20-Year Term Life Insurance Application

MetLife
Metropolitan Life Insurance Company
New York, NY 10166

Group Customer: Collegiate Alumni Trust - Group Customer #156129

Applicant

_____
Title (Dr. / Mr. / Mrs. / Ms.), First Name, Middle Initial, Last Name

_____
Mailing Address

_____ _____ _____ _____
City *State* *Zip Code* *Phone 1* ❑ Home ❑ Work ❑ Cell

_____ _____ _____
Social Security # *Email* *Phone 2* ❑ Home ❑ Work ❑ Cell

Birth Date _____ Gender _____ Occupation _____ Preferred Phone ❑ Home ❑ Work ❑ Cell
MM/DD/YY *M/F*

My eligibility status is *(check one)*: ❑ Alumnus/a ❑ Student ❑ Faculty/Staff Member ❑ Eligible Family Member
If Eligible Family Member *(check one)*: ❑ Spouse/Domestic Partner ❑ Parent ❑ Adult Child ❑ Adult Sibling

Sponsoring college, university, school, or alumni/ae association: _____

	Yes	No
By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you?	❑	❑

I request coverage for the benefits for which I am eligible. I understand that premium payments are required for the benefits I select below.

A. Insurance Requested.* I request:
❑ $2 million (max) ❑ $1.5 million ❑ $1 million ❑ $500,000 ❑ $250,000 ❑ $100,000 (min) ❑ Other $_____ *($1,000 increments)*

B. Term: ❑ 10-Year. By electing the 10-Year Term option I acknowledge I have read the 10-Year Term brochure and am under age 75.

❑ 20-Year. By electing the 20-Year Term option I acknowledge I have reviewed the 20-Year Term plan provisions, limitations, and premiums at www.AlumL4L.com and I am under age 65.

**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.*

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ADM

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

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FW

C. Health Information. Please provide full details below. Do not leave blank. If not applicable, write "n/a".

1. Personal Physician _____
Name *Address* *Phone*

Date of Last Visit _____ Reason _____ Are you currently taking any prescribed medications? ❑ Yes ❑ No
MM/DD/YY

2. List Medication(s) _____ Condition/diagnosis _____

Prescribing Physician _____
Name *Address* *Phone*

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.

		Yes	No
1.	Height _____ *Ft* _____ *In* Weight _____ *Lbs.*		
2.	Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type: _____	❑	❑
3.	Are you now pregnant? If "yes," what is your due date (MM/DD/YY)? _____	❑	❑
4.	Are you now using, or have you in the past 5 years used, tobacco in any form?	❑	❑
5.	In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	❑	❑
6.	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) (MM/DD/YY) _____	❑	❑

		Yes	No
7.	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?	❑	❑
8.	Are you now receiving or applying for any disability benefits, including workers' compensation?	❑	❑
9.	Have you been "Hospitalized" as defined below (not including well-baby delivery) in the past 90 days? *Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.*	❑	❑
10.	**For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	❑	❑
	For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	❑	❑

11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

a.	cardiac or cardiovascular disorder?	❑	❑
b.	stroke or circulatory disorder?	❑	❑
c.	high blood pressure?	❑	❑
d.	cancer, Hodgkins disease, lymphoma or tumors? Indicate type: _____	❑	❑
e.	anemia, leukemia or other blood disorder? Indicate type: _____	❑	❑
f.	diabetes? Your age at diagnosis? _____ ❑ Check if insulin treated	❑	❑
g.	asthma, COPD, emphysema or other lung disease? Indicate type: _____	❑	❑
h.	ulcers, stomach, hepatitis or other liver disorder? Indicate type: _____	❑	❑
i.	colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type: _____	❑	❑
j.	memory loss?	❑	❑
k.	epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type: _____	❑	❑
l.	Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	❑	❑
m.	multiple sclerosis, ALS or muscular dystrophy?	❑	❑
n.	lupus, scleroderma, auto immune disease or connective tissue disorder?	❑	❑
o.	arthritis? ❑ osteoarthritis ❑ rheumatoid ❑ other/type: _____	❑	❑
p.	back, neck, knee, spinal, joint or other musculoskeletal disorder?	❑	❑
q.	carpal tunnel syndrome?	❑	❑
r.	kidney, urinary tract or prostate disorder? Indicate type: _____	❑	❑
s.	thyroid or other gland disorder? Indicate type: _____	❑	❑
t.	mental, anxiety, depression, attempted suicide or nervous disorder?	❑	❑
u.	sleep apnea?	❑	❑

Please provide full details here for each "Yes" answer to questions 2-11. 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. ❑ Check if attaching additional sheet

Question #_____ Condition/Diagnosis_____ Date of Diagnosis _____ *MM/DD/YY* Medication Prescribed? ❑ Yes ❑ No

1. Treating Physician_____
Name *Address* *Phone*

Type of Treatment_____ Date of Last Treatment _____ *MM/DD/YY*

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HEA

D. Beneficiary Information. 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 application and I revoke any previous beneficiary designation. I understand I have the right to change this designation at any time. ❑ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information and sign/date the page.

1._____% _____
Full Name/Relationship *Mailing Address* *Phone* *Social Security #* *Birthdate*

2._____% _____
Full Name/Relationship *Mailing Address* *Phone* *Social Security #* *Birthdate*

3._____% _____
Full Name/Relationship *Mailing Address* *Phone* *Social Security #* *Birthdate*

Declarations and Signature. By signing below, I acknowledge: 1. I have read this application 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 am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities. 3. I have read the Beneficiary Designation section provided in this application and I have made a designation if I so choose. 4. I have read the applicable Fraud Warning(s) provided in this application.

Applicant's Signature X _____ Print Name: _____ Date: _____
(The Applicant signs here. Please sign in ink.)

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DEC

Collegiate Alumni Trust
EF-STS143-NW

Applicant signs as indicated above and mails this request and the enclosed Authorization Forms to the Administrator:
Meyer and Associates ◆ 18 Washington Avenue ◆ Chatham, NJ 07928 ◆ 800-635-7801 Weekdays 8:30AM-6:00PM ET ◆ www.AlumL4L.com

MetLife
Metropolitan Life Insurance Company
New York, NY

MetLife Authorization Form

Submission Instructions
Complete, sign, and date both sides of this form.
Make a copy for your records and return it with your life insurance enrollment form to:
Meyer and Associates, 18 Washington Ave., Chatham, NJ 07928
info@meyerandassoc.com • 800-635-7801 Weekdays 8:30am-6:00pm ET

Applicant: _____
Title (Dr. / Mr. / Mrs. / Ms.), First Name, Middle Initial, Last Name

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) (Members, including alumnus/alumna, spouse, and any other person(s) named below). 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.

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. Any action taken before MetLife receives the 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. I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.
- 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 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 has a right to receive a copy of this form.

Please Sign Both Sides Of This Form

Applicant's Signature X _____ Date _____

State of Birth _____ Country of Birth _____

Meyer and Associates

Collegiate Alumni Trust Authorization Form

Submission Instructions

Complete, sign, and date both sides of this form.
Make a copy for your records and return it with your life insurance enrollment form to:
Meyer and Associates, 18 Washington Ave., Chatham, NJ 07928
info@meyerandassoc.com • 800-635-7801 Weekdays 8:30am-6:00pm ET

Applicant: _____
Title (Dr. / Mr. / Mrs. / Ms.), First Name, Middle Initial, Last Name

Sponsor: _____ (Sponsoring college, university, school, or alumni/ae association)

Policyholder: Collegiate Alumni Trust II (CAT)
Administrator: Meyer and Associates

I apply to become a Subscriber to the Collegiate Alumni Trust. CAT enables members of sponsoring organizations to purchase insurance through a single group insurance policy. Subscribing to CAT costs nothing, but is required to become insured. I understand that this program is for my benefit. I request that any dividend or surplus to which I may be entitled as the result of my participation be paid to the Sponsor named above or to any other entity designated by the Sponsor from time to time. I understand that I am not required to do so and may rescind this request by contacting Meyer and Associates at the address above. I authorize email communication from Meyer and Associates about my application and insurance.

Please Sign Both Sides Of This Form

SIGN & DATE

Applicant's Signature X _____ Date _____

Privacy Statement of Meyer and Associates

Meyer and Associates manages insurance programs for alumni. To the extent permitted by law, we do not, and shall not, allow anyone else, except the companies that provide your coverage, to access any information about you. Thus, you will never receive mail, except through us, because you purchased insurance through us.

We use your proprietary customer information within our company for our own marketing purposes, including using such information to offer you products and services from carefully selected companies. We do not share your information with other companies, but instead we send such offers directly. If at any time you prefer that we not use your information to send you other offers, please notify Meyer and Associates in writing at the address above, and include your name, address, and account number. Such a notice will not affect any provision of our products or services.

Your decision to permit or restrict our use of your information will be honored until you decide to change it, which you can do at any time by contacting us.

Fraud Warning(s): 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.