Application for Policy Change

Term Conversion
Policy Change
Exercise Options Available Under Existing Policy
Policy Reinstatement

☐ Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

☐ Metropolitan Tower Life Insurance Company
200 Park Avenue
New York, NY 10166

Application Completion Instructions:

Part I (Questions 1-17) requests information about the type of change requested, conversion requested, reinstatement requested, or option being exercised. If evidence of insurability is <u>not</u> required, after completing Part I, proceed to the Agreement/Disclosure page.

Part II (Questions 18-29) needs to be completed <u>only</u> when Evidence of Insurability is required in connection with the change requested, conversion requested, reinstatement requested, or option being exercised. This section should be answered for all persons to be insured.

If either a Child Term Rider or a Covered Insured Rider is applied for, use the Other Insureds supplement to provide details on all persons to be insured under those riders.

Company Use Only **(New Policy Numbers/Billing/MSA Number)**

PERSONAL LIFE INSURANCE POLICY(IES) APPLICATION FOR (Check all that apply):
☐ **TERM CONVERSION** ☐ **POLICY CHANGE** ☐ **REINSTATEMENT** ☐ **EXERCISE OF OPTIONS**

Policy to be issued by:
☐ **Metropolitan Life Insurance Company** ☐ **Metropolitan Tower Life Insurance Company**

The Company indicated above is referred to as "the Company".

PART I

1. EXISTING POLICY INFORMATION FOR CHANGE OR OPTION REQUESTED.

a) Name of Insured #1:

b) Name of Insured #2:

c) Existing Policy Number(s) & company:

2. REINSTATEMENT (If this form is being used for reinstatement ONLY, complete Questions 18-30.)

a) ☐ Policy Reinstatement **b)** Payment being submitted with this application: $

3. CONVERSION

a) Policy Conversion: ☐ Full (No balance to be retained.) ☐ Partial -Amount of Term retained: $

b) Rider Conversion: Type of Rider:
☐ Full (No balance to be retained.) ☐ Partial -Amount of Rider retained: $

c) Child Rider Conversion/Option: Child's Name:
Date of Birth: mm/dd/yy Social Security No.:

d) New Plan: **e)** New Face Amount: $ **f)** New Policy Date: mm/dd/yy

g) New Benefits/Rider/Options:
Type: Amount: $ (if required)
Type: Amount: $ (if required)
Type: Amount: $ (if required)

4. EXERCISE: ☐ **GUARANTEE ISSUE RIDER** ☐ **GUARANTEE VALUE RIDER** ☐ **PURCHASE OPTION RIDER**

a) ☐ Exercise Scheduled Option
b) ☐ Exercise Advanced Option due to Marriage Date of Marriage: mm/dd/yy
c) ☐ Exercise Advanced Option due to Birth or Adoption Date of Birth or Adoption: mm/dd/yy
d) ☐ Other
e) New Plan of Insurance: **f)** New Face Amount: $
g) Benefits/Riders: **h)** New Policy Date: mm/dd/yy

5. POLICY CHANGE

a) ☐ Improvement of Classification for: ☐ Insured #1 ☐ Insured #2
☐ Removal of Exclusion for: ☐ Insured #1 ☐ Insured #2
Reason:

b) ☐ Increase ☐ Decrease Face Amount
Face amount **after Change:** $

c) ☐ Increase ☐ Decrease Rider
Rider type:
Rider amount **after Change:** $

d) Change Death Benefit/Contract Type to:

e) ☐ Add ☐ Delete Benefit
Benefit type:

f) ☐ Add ☐ Delete Rider
Rider type:
Face/Rider amount **after Change:** $

g) Other:

6. EXERCISE OPTIONS

a) ☐ Expiry of Extra Protection
b) ☐ Expiry of Child's Term Insurance Benefit and/or Insured Child Rider under a family policy
c) ☐ Surviving Insured Joint Term Policy
d) ☐ Modified Premium Life Policy (MPL) Additional Insurance Option
e) ☐ Exchange Insurance to a substitute Insured (attach New Business Application)
f) ☐ Other:
g) New Plan of Insurance:
h) New Face Amount: $
i) Benefits/Riders:
j) New Policy Date: mm/dd/yy

7. OTHER POLICY CHANGES/OPTIONS/SPECIAL REQUESTS: (For any changes to the policy not previously indicated, give full details.)

8. COMPLETE THIS SECTION FOR UNIVERSAL/VARIABLE LIFE PRODUCTS. IF A VARIABLE LIFE PRODUCT, ALSO COMPLETE VARIABLE LIFE SUPPLEMENT.

I. For MetLife Products

a) Planned Premium Amount (modal): $ **b)** Excess Premium Amount: $

c) Definition of Life Insurance Test: ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

d) Death Benefit Option: ☐ Option A (Specified Face Amount)
☐ Option B (Specified Face Amount PLUS the accumulation fund or cash value)
☐ Option C (Variable Life only - Option A to age 65, Option B thereafter)

e) Guarantee to (for Variable Life only): ☐ Age 65 ☐ Age 75 ☐ Age 85 ☐ 5 years

9. Existing or applied for insurance, including any term riders, or annuity: (If additional space is needed, provide details in the Supplemental Information Section.) If no existing or applied for insurance or annuity, check here. ☐

(Type: Life (L), Disability (D), Health (H), Annuity (A))

Insured	Company	Type (L,D,H,A)	Amount	Year of Issue	Accidental Death Amount	1035
						☐ Yes
						☐ Yes
						☐ Yes
						☐ Yes

10. In connection with this application, has there been, is there intended to be, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? (If Yes, complete the Replacement Questionnaire and Disclosure and any applicable replacement forms. Check No if this application is a contractual change or an exempt replacement transaction.) ☐ Yes ☐ No

11. Is any person to be insured a dependent spouse or dependent minor? (If Yes, provide details below.) ☐ Yes ☐ No

a) Amount of insurance on spouse: Existing: $ _____ Applied For: $ _____

b) If dependent minor, are there any other siblings insured for less than this child? (If Yes, provide details in Supplemental Information Section.) ☐ Yes ☐ No

c) Amount of existing and applied for insurance on parents of dependent minor:

	Amount			Amount	
Father's Name	Existing	Applied For	Mother's Name	Existing	Applied For

OWNER/BENEFICIARY: If this application is being used: to **convert a term policy or rider; or to exercise an option**, this section MUST be completed.

If this application is being used: to **reinstate a policy; or to make a change to an existing policy**, this section need NOT be completed.

☐ Check here if the Owner and Beneficiary designations shown below also apply to the original existing policy referenced in Question 1 of this application.

Provide the following information for all Primary/Contingent Owners and Beneficiaries:

Name; relationship to insured(s); date of birth; social security/tax ID number; and address. Include e-mail address. If Trust, provide Trustee Name and Date of Trust. Indicate additional: Owners; Contingent Owners; Primary Beneficiaries; and Contingent Beneficiaries in Supplemental Information Section.

12. Owner/ Contingent Owner information

a) Identity of Owner: Insured #1 ☐ #2 ☐

b) Identity of Contingent Owner (if applicable):

13. Beneficiary Information

Note: Multiple Beneficiaries will receive equal proceeds unless otherwise requested by Owner.

a) Identity of Primary Beneficiary: ☐ Owner

b) Identity of Contingent Beneficiary:

☐ Check here if all present and future children born of the marriage of the insured, (name) _____ and current spouse, (name) _____, are to be included as Contingent Beneficiaries.

14. MODE OF PAYMENT – Complete only for newly applied policies if the mode is to be different than on the existing policy.

a) Mode of Payment: ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly ☐ Bank Draft ☐ Special Accts _____ ☐ Other _____

(Additional details/ existing/new account numbers, etc.:) _____

b) Amount Collected with Application $_____ must equal at least one monthly premium.

15. SOURCE OF FUNDS (Check all that apply:)

☐ Earned Income ☐ Money Market Fund ☐ Certificate of Deposit
☐ Rollover/Transfer of Assets ☐ Savings ☐ Loan ☐ Other _____
☐ Mutual Fund/Brokerage Acct. ☐ Use of values in another Life Insurance/Annuity Contract

16. What is the purpose of this insurance? (Check all that apply.) ☐ Income Protection ☐ Business Planning

☐ Estate Planning ☐ Mortgage Protection ☐ Retirement Supplement ☐ Education Funding
☐ Final Expenses ☐ Charitable Giving ☐ Other _____

17. ADDRESS of persons to be insured under any policy that results from the conversion, change or option exercise requested in this application. Complete for newly applied for policies only if the addresses are different than the addresses on the existing policy.

Insured #1: Current residence Address

(Street)

(City/State) (Zip)

Insured #2: Current residence Address

(Street)

(City/State) (Zip)

Premium Payer's name and mailing address:

(Name)

(Street)

(City/State) (Zip)

Supplemental Information Section or Special Requests from Agent/Producer. Provide Question number and Insured name if necessary.

Continue with Part II, questions 18-29, if Evidence of Insurability is required.

If Evidence of Insurability is not required, proceed to Agreement/Disclosure Page.

PART II - To Be Completed When Evidence of Insurability is Required

18. Identity of Person(s) to be Insured: Life 1; and Life 2 or Spouse/Covered Insured/Applicant's Waiver of Premium Benefit. (For multiple persons under a Covered Insured rider, complete the Other Insureds Supplement.)

Name: First, Middle, Last	Sex	DOB Mo/ Day/ Yr	State/Country of Birth	Social Security No.	Relationship to Proposed Insured #1
Proposed Insured #1:		mm/dd/yy			SELF
Proposed Insured #2:		mm/dd/yy			

Proposed Insured #1	Proposed Insured #2
19. Employer's Name:	Employer's Name:
Occupation: (Job Title & Duties)	Occupation: (Job Title & Duties)
Earned Annual Income: $ Net Worth: $	Earned Annual Income: $ Net Worth: $
Are you actively at work? ☐ Yes ☐ No (if No, provide details.)	Are you actively at work? ☐ Yes ☐ No (if No, provide details.)

20. Within the past 3 years has any person to be insured flown in a plane other than as a passenger on a scheduled airline or have plans for such activity within the next year? (If Yes, complete Aviation Supplement.) ☐ Yes ☐ No

21. Within the past 3 years has any person to be insured participated in or intend to participate in any: underwater sports (SCUBA diving, hardhat, skin diving, snorkeling); sky sports (skydiving, hang gliding, parachuting, ballooning); racing sports (motorcycle, auto, motor boat); rock or mountain climbing; bungee jumping; or other similar activities? (If Yes, complete Avocation Supplement.) ☐ Yes ☐ No

22. Are all persons to be insured U.S. citizens? (If No, provide details below including: country of citizenship; Visa/ID Card type; number; and expiration date.) ☐ Yes ☐ No

23. Does any person to be insured intend to travel or reside outside the U.S. or Canada in the next 12 months? (If Yes, provide details below including: country; city; duration; and purpose.) ☐ Yes ☐ No

24. Has any person to be insured ever used tobacco products: (e.g. cigarettes; cigars; pipes; smokeless tobacco; chew) or nicotine substitutes: (e.g. patch or gum)? (If Yes, provide, type, amount, date last used, and frequency below.) ☐ Yes ☐ No

25. Has any person to be insured: ever had a driver's license suspended or revoked; ever been convicted of DUI or DWI; or had any moving violations in the last 5 years? (If Yes, provide details below.) ☐ Yes ☐ No

Name	Question Number(s)	Date	Details
		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	

26.	Has any person proposed for insurance EVER received treatment, attention, or advice from any physician, practitioner or health facility for, or been told by any physician, practitioner or health facility that he/she had: (Provide details for each Yes answer below.)	
a)	High blood pressure; chest pain; heart attack; or any other disease or disorder of the heart or circulatory system?	☐ Yes ☐ No
b)	Asthma; bronchitis; emphysema; sleep apnea; shortness of breath; or any other disease or disorder of the respiratory system?	☐ Yes ☐ No
c)	Seizures; stroke; paralysis; Alzheimer's disease; multiple sclerosis; Parkinson's; or any other disease or disorder of the brain or nervous system?	☐ Yes ☐ No
d)	Ulcers; colitis; hepatitis; cirrhosis; or any other disease or disorder of the liver, gallbladder, stomach, or intestines?	☐ Yes ☐ No
e)	Any disease or disorder of: the kidney; bladder; or prostate; or protein or blood in the urine?	☐ Yes ☐ No
f)	Diabetes; thyroid disorder; or any other endocrine disorder?	☐ Yes ☐ No
g)	Arthritis; gout; or disorder of the muscles, bones, or joints?	☐ Yes ☐ No
h)	Cancer; tumor; polyp; cyst; anemia; leukemia; or any other disorder of the blood or lymph glands?	☐ Yes ☐ No
i)	Depression; stress; anxiety; or any other psychological or emotional disorder or symptoms?	☐ Yes ☐ No

27.	Has any person proposed for insurance: (Provide details for each Yes answer below.)	
a)	In the past six months, taken any medication or been under observation or treatment?	☐ Yes ☐ No
b)	Scheduled any: doctor's visits; medical care; or surgery for the next six months?	☐ Yes ☐ No
c)	During the past five years had any: checkup; health condition; or hospitalization not revealed above?	☐ Yes ☐ No
d)	Ever been diagnosed with, or treated by a medical professional for: Acquired Immune Deficiency Syndrome (AIDS); or AIDS Related Complex (ARC)?	☐ Yes ☐ No
e)	Ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?	☐ Yes ☐ No
f)	Have you ever received treatment from a physician or counselor regarding the use of alcohol, or the use of drugs except for medicinal purposes; or received treatment or advice from an organization that assists those who have an alcohol or drug problem?	☐ Yes ☐ No

Give details of each Yes answer in questions 26 and 27. Attach additional sheet(s) if necessary.

Name	Question Number	Name/Address of Physician	Date/Duration of Illness	Diagnosis/Severity Treatment

28. Attending Physician(s) of the Proposed Insured(s): (Provide: name; address; phone number; date; and reason for last consultation. Attach additional sheet(s) if necessary.)

Proposed Insured #1	
Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment
Proposed Insured #2	
Physician's name, address and phone number	Date/Reason/Diagnosis/Treatment

29. Has a parent or sibling of any person to be insured ever had: heart disease; coronary artery disease; high blood pressure; cancer; diabetes; or mental illness? (If Yes, complete rest of question 29.) ☐ Yes ☐ No

Relationship to Life #1:	Age(s) if Living	Age(s) at Death	State of Health(Specific Conditions)or Cause of Death (Attach additional sheet(s) if necessary.)
Relationship to Life #2	**Age(s) if Living**	**Age(s) at Death**	**State of Health(Specific Conditions)or Cause of Death (Attach additional sheet(s) if necessary.)**

Supplemental Information Section – Provide Question number and details. Attach additional sheet(s) if necessary.

Name	Question Number	Details

AGREEMENT/DISCLOSURE

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- In this Agreement, "the Company" means the insurer which issues the new or changed policy(ies).
- This application and any amendment(s) and supplement(s) will be attached to and become part of the new or changed policy(ies).
- The basis of any policy issued or reinstated or of any additional benefits granted are:
  - My statements in this application and any amendment(s), paramedical/medical exam and supplement(s); and
  - My statements in the application(s), amendment(s), paramedical/medical exam, questionnaire(s) and supplement(s) for the original policy(ies).
- Only the Company's President, Secretary or Vice-President may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt or policy.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- If I intend to replace existing insurance or annuities, I have so indicated in question 10 of this application.
- I have received the Company's Consumer Privacy Notice and, as required, the Life Insurance Buyer's Guide.
- If I was required to sign an HIV Informed Consent Authorization, I have received a copy of that Authorization.
- I understand that receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. A discount is associated with the acceleration and an administrative charge will be required upon exercise of the benefit.

If I have applied for a Change or a Conversion or have applied to exercise an Option, I also agree that:

- The answers given in this application may be relied upon in deciding whether to grant a conversion, or change request. Any conversion or change in coverage provided in reliance on such answers is contestable to the extent set forth in the resulting policy or rider. However, where coverage provided under the original policy continues, such coverage remains contestable as set forth in the original policy or rider.
- The Company will not be liable under this application until a policy is delivered and any premium due is paid. But, if Part II of this application was required to be completed, the policy will not be in effect unless at the time it is delivered: (a) the health of each person to be insured is the same as given in the application; and (b) no person to be insured has received any medical advice or treatment from a licensed medical practitioner since the date of this application.
- Any new policy will be subject to any assignment of or restriction on the original policy(ies). Except where the original policy(ies) stay(s) in force, any policy loan will be charged to the new policy(ies) as a policy loan. It will be subject to the terms of the new policy(ies).
- Any dividend held under the original policy(ies), or other credit from the conversion or change, will: (a) be transferred to the new policy(ies); or (b) paid to the owner(s) of the new policy(ies); or (c) remain with the original policy(ies).
- If I am exercising an option to convert a rider (such as a spouse term rider or child term rider), and the person insured under the rider dies before this application is processed: (a) the Company will return any premiums paid with this application to the Beneficiary named in this application; (b) the amount of insurance paid will be the amount of insurance under the rider in the original policy; and (c) in the absence of any designation to the contrary, the beneficiary and ownership designation of the original policy will remain the same.

If I have applied for a Reinstatement of an existing policy, I also agree that:

- The reinstatement requested herein shall take effect only when and if: this application is approved by the Company; and provided that the full amount due is received by the Company.
- The answers given in this application may be relied upon in deciding whether to reinstate a policy or benefit. Any coverage or benefit reinstated in reliance on such answers is contestable for two years from the date of such reinstatement (1 year if the policy provides for incontestability 1 year from the date of the policy).
- If the policy is not reinstated, any amount paid for reinstatement will be returned without interest.

Substitute Form W-9 - Request for Taxpayer Identification Number

Owner's Taxpayer Identification Number: _____

Under penalties of perjury I _____ **certify:**
(Owner's Name)

1) **That the number shown above is my correct taxpayer identification number; and**
2) **That I am not subject to backup withholding because: (a) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends; or (b) the IRS has notified me that I am no longer subject to backup withholding; and**
3) **I am a U.S. citizen or a U.S. resident for tax purposes.***

Please note: Cross out and initial item 2 if subject to backup withholding as a result of a failure to report all interest and dividend income.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

*If you are not a U.S. citizen or a U.S. resident for tax purposes, please complete form W-8BEN.

SIGNATURES:

	Signed at City, State	Mo./Day/Year	Signature
Owner Before Change* (age 14 1/2 or over)		mm/dd/yy	
Owner After Change* (if different) (age 14 1/2 or over)		mm/dd/yy	
Collateral Assignee (Before Change, If any)		mm/dd/yy	
Proposed Insured #1 (If Part II is not completed, signature of Insured #1.) (Age 14 1/2 or over)		mm/dd/yy	
Proposed Insured #2 (If Part II is not completed, signature of Insured #2.) (Age 14 1/2 or over)		mm/dd/yy	
Parent or Guardian or person liable for child's support (Signature required if Owner, insured, or proposed insured(s) is/are under the age of 18 and the parent, guardian or person liable for the child's support has not signed above)		mm/dd/yy	
Witness to Signatures (Licensed Agent/Producer)		mm/dd/yy	

***If the Owner is a Firm or Corporation, include Officer's title with signature. (Officer signing must be other than a proposed insured.)**

If evidence of insurability is required, complete the *Authorization.*