

Underwritten by Metropolitan Life Insurance Company (MetLife)

NexGen

ADULT FORMER DEPENDENT LIFE

Welcome to Military Benefit Association (MBA)

We are a nonprofit organization of military personnel, civilian employees of the United States Government, veterans, their spouses, and dependent/former dependent children. We sponsor for 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.

**MILITARY
BENEFIT
ASSOCIATION**



ELIGIBILITY

You are eligible if you were at one time a dependent child of an MBA member or former MBA member and you are at least age 21 but under age 62.

COVERAGE FEATURES

Amounts Available

As an eligible applicant, you may apply for group term life insurance in amounts up to \$250,000, in units of \$50,000.

Continuous Coverage to Age 70

24 hours a day, anywhere in the world, during times of war and peace. Coverage ends at age 70.

Emergency Death Benefit¹

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

Accelerated Benefits Option²

For access to funds during a difficult time

You can receive up to 80% of your Term Life insurance proceeds to a maximum of \$200,000 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.

Effective Date of Insurance

Coverage becomes effective on the first day of the month following both (a) approval of your application for insurance and (b) receipt by MBA of the required premium. Please note that the effective date of coverage will be delayed if illness prevents you from completing a day of regular employment or if you are confined to a hospital, at home under the care of a physician for any medical reason, or if you have applied to receive or are receiving disability income from any source for any medical reason.

Conversion Privilege

Members have a conversion privilege upon the occurrence of certain events, including upon termination of group coverage, at age 70, to an individual policy of life insurance with MetLife, as explained in the certificate of coverage.

Exclusion

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

Cancellation Protection, Termination

Life insurance coverage cannot be terminated by the insurer prior to age 70, 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.

ADULT FORMER DEPENDENT LIFE MONTHLY PREMIUM/COVERAGE (MALES)

	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Non Tobacco	Thru 29	\$6.88	\$10.83	\$15.00	\$19.17	\$23.33
	30-34	\$7.50	\$12.08	\$16.88	\$21.67	\$26.46
	35-39	\$8.75	\$13.75	\$19.38	\$25.00	\$30.63
	40-44	\$11.46	\$19.17	\$27.50	\$35.83	\$44.17
	45-49	\$16.67	\$30.42	\$44.38	\$58.33	\$72.29
	50-54	\$20.83	\$36.25	\$53.13	\$70.00	\$86.88
	55-59	\$25.00	\$48.75	\$71.88	\$95.00	\$118.13
	60-64	\$39.17	\$75.83	\$112.50	\$149.17	\$185.83
	65-69	\$62.50	\$122.08	\$181.88	\$241.67	\$301.46
	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Tobacco	Thru 29	\$13.76	\$21.66	\$30.00	\$38.34	\$46.66
	30-34	\$15.00	\$24.16	\$33.76	\$43.34	\$52.92
	35-39	\$17.50	\$27.50	\$38.76	\$50.00	\$61.26
	40-44	\$22.92	\$38.34	\$55.00	\$71.66	\$88.34
	45-49	\$33.34	\$60.84	\$88.76	\$116.66	\$144.58
	50-54	\$41.66	\$72.50	\$106.26	\$140.00	\$173.76
	55-59	\$50.00	\$97.50	\$143.76	\$190.00	\$236.26
	60-64	\$78.34	\$151.66	\$225.00	\$298.34	\$371.66
	65-69	\$125.00	\$244.16	\$363.76	\$483.34	\$602.92

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.

ADULT FORMER DEPENDENT LIFE MONTHLY PREMIUM/COVERAGE (FEMALES)

	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Non Tobacco	Thru 29	\$5.21	\$8.33	\$11.25	\$14.17	\$17.08
	30-34	\$6.04	\$10.00	\$13.75	\$17.50	\$21.25
	35-39	\$7.50	\$11.25	\$15.63	\$20.00	\$24.38
	40-44	\$10.21	\$17.92	\$25.63	\$33.33	\$41.04
	45-49	\$12.29	\$20.83	\$30.00	\$39.17	\$48.33
	50-54	\$14.17	\$25.00	\$36.25	\$47.50	\$58.75
	55-59	\$20.83	\$37.92	\$55.63	\$73.33	\$91.04
	60-64	\$35.00	\$66.67	\$98.75	\$130.83	\$162.92
	65-69	\$51.04	\$98.75	\$146.88	\$195.00	\$243.13
	AGE	\$50,000	\$100,000	\$150,000	\$200,000	\$250,000
Tobacco	Thru 29	\$10.42	\$16.66	\$22.50	\$28.34	\$34.16
	30-34	\$12.08	\$20.00	\$27.50	\$35.00	\$42.50
	35-39	\$15.00	\$22.50	\$31.26	\$40.00	\$48.76
	40-44	\$20.42	\$35.84	\$51.26	\$66.66	\$82.08
	45-49	\$24.58	\$41.66	\$60.00	\$78.34	\$96.66
	50-54	\$28.34	\$50.00	\$72.50	\$95.00	\$117.50
	55-59	\$41.66	\$75.84	\$111.26	\$146.66	\$182.08
	60-64	\$70.00	\$133.34	\$197.50	\$261.66	\$325.84
	65-69	\$102.08	\$197.50	\$293.76	\$390.00	\$486.26

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.

HOW TO APPLY

Complete the Enrollment 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 the NexGen Adult Former Dependent application through MBA with MetLife is \$250,000.

Return the Enrollment Application

Form — You must meet eligibility for membership requirements on the effective date of insurance coverage. Therefore, enrollment application forms must be approved and payment of the first month's premium must be received while you are still eligible. Enrollment application forms should be received at least three months before termination of eligibility.

Enclose Your Method of Payment — To pay monthly premiums 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.

To pay premium by credit card, please complete and enclose the Credit Card Authorization Form.

To pay your premium by check or money order, please enclose a check or money order payable to MBA for three months of premium with the enrollment application form. You will be billed quarterly or semi-annually for future premiums.

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.

Like most group insurance policies, MetLife's policies contain certain exclusions, exceptions, waiting periods, reductions, limitations and terms for keeping them in force. Association Group Term Life Insurance is issued by Metropolitan Life Insurance Company (MetLife), New York, NY, policy form # 149107-1-G.

¹ Benefit is payable after 2 years and cannot exceed 50% of coverage.

² 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.



AUXILIARY MEMBER (NEXGEN ADULT FORMER DEPENDENT) ENROLLMENT •CHANGE FORM

SECTION 1 – Your Enrollment Information (To be Completed by the Auxiliary Member)
NexGen Adult Former Dependent

Auxiliary Member's Name (First, Middle, Last)		Auxiliary Member's SSN # - -	Date of Birth (MM/DD/YYYY)
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Current Mailing Address (Street, City, State, Zip Code)			
Home/Cell Phone #	Work Phone #	Personal Email Address	

SECTION 2 – Member (Sponsor) Information

Member (sponsor's) Name (First, Middle, Last)	Member (sponsor's) SSN # - -
---	---------------------------------

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.

I understand health information is not required if I enroll within 90 days after my eligibility under NexGen Child coverage ends and:

- if previously enrolled for \$10,000, I am eligible to increase coverage up to \$50,000.
- if previously enrolled for \$20,000 or \$25,000; I am eligible to increase coverage up to \$100,000.

Auxiliary Member Life Insurance ¹

\$50,000 \$100,000 \$150,000 \$200,000 \$250,000

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, Servicemembers Group Life Insurance (SGLI) or Federal Employees' Group Life Insurance (FEGLI))? 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.

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

Name of Group Customer/Association Military Benefit Association (MBA)	Group Customer # 0149107	Experience #	Report #	Sub Code
Date of Membership (MM/DD/YYYY)	Member ID #	Coverage Effective Date (MM/DD/YYYY)		

GEF02-1 ADM
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana; GEF02-1 ADM applies to residents of Connecticut, North Dakota and Utah)

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.

SECTION 4 - Payment Information

- A completed EFT authorization (monthly only) form from my checking account.
- A completed credit/debit card authorization for automatic payment.
- Military Allotment Authorization (complete the Request for Allotment section of the Additional Forms and Information sheet)
- 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

SECTION 5 – Tobacco Use

Have you used tobacco in any form in the past 12 months?

Auxiliary Member
 Yes No

GEF02-1**ADM**

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF02-1

ADM applies to residents of Connecticut, North Dakota and Utah)

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.

Auxiliary Member 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 6, for “yes” answers, please provide full details in the sections below.

Auxiliary 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. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? Yes No
 If “yes”, specify “date(s) of conviction(s) (month/day/year) _____
5. **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? Yes No
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? Yes No
6. 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

GEF09-1**HEA**

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF09-1

HEA applies to residents of Connecticut, North Dakota and Utah)

For questions 7 and 8, for “yes” answers, please provide full details in the sections below.

7. In the past 5 years, have you been **Hospitalized** as defined below (not including well-baby delivery)? Yes No

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.

8. 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

Please provide full details-below for each “Yes” answer to questions 3 through 8.

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 7 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

GEF09-1
HEA-SUPP
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;
GEF09-1
HEA-SUPP *applies to residents of Connecticut, North Dakota and Utah)*

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 insurance policy 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:** A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing 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 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 purposes 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.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number GEF09-1 applies to residents of Montana;
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

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.

GEF09-1

FW

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

GEF09-1

FW applies to residents of Connecticut, North Dakota and Utah)

SECTION 8 – Beneficiary Designation for Auxiliary Member Insurance

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.

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 #	
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):

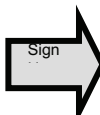
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	

Payment will be made in equal shares or all to the survivor unless otherwise indicated. TOTAL: 100%

SECTION 9 – Declarations and Signatures

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 active duty, regular employment or normal activities on the date I am enrolling. I understand that if I have not completed a day of active duty, 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 insurance for a person is scheduled to take effect, the person must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the person does not meet this requirement on such date, the insurance will take effect on the date the person 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 Auxiliary Member _____	Print Name _____	Date Signed (MM/DD/YYYY) _____

GEF09-1

DEC

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

GEF09-1

DEC applies to residents of Connecticut, North Dakota and Utah)

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. . If submitted electronically, I CERTIFY the applicant completed Section 9 and the Authorization form.

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 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 second day of each month debit entries to my checking account indicated below and on the attached voided check, and I hereby authorize the depository institute 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 that if any such debit is 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)

Date

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

Complete for Credit Card Authorization Only

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 MasterCard Discover

Alt / Cell Number

Card Number

Expiration Date

(Select One Payment Option:)

See premium table to compute payment amount.

Quarterly Payment \$

Semi-Annual Payment \$

Annual Payment \$

(Monthly Premium X 3)

(Monthly Premium X 6)

(Monthly Premium X 12)

Please charge my card automatically for recurring payments.

(You will not be billed for future payments, they will be deducted automatically)

YES

NO

I hereby authorize Military Benefit Association to initiate charges to the credit card indicated above. These charges will 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 that if any such debit is 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.

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.



Signature of Auxiliary Member	Date Signed (MM/DD/YYYY)
Print Name	State of Birth
	Country of Birth

ADDITIONAL FORMS & INFORMATION

REQUEST FOR ALLOTMENT

TO: Disbursing or Finance Office

Date _____

I request that an allotment be started in the amount of \$ _____ for Policy No. GP01 payable to:

MILITARY BENEFIT ASSOCIATION, 14605 AVION PARKWAY, P.O. BOX 221110, CHANTILLY, VA 20153-1110

Service Member's Last Name First Name Middle Initial

Service Member's Social Security Number

Service Member's Rate/Rank Branch of Service

First monthly deduction effective _____
Month Year

Blanket Company/Allotment Codes for MBA

USA K002111 USMC 0065

USN N06002 USCG 065

USAF N060025

Signature of Service Member

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife Health Plans, Inc.
SafeHealth Life Insurance Company

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.

1. 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, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

2. 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.

3. 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 legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

4. 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, or by contacting MIB at www.mib.com.

5. 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

6. 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

7. 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.

8. 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 locatable and retrievable. 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.

9. 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 the MetLife companies listed at the top of the first page.

**MILITARY
BENEFIT
ASSOCIATION**



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



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

© 2019 MetLife Services and Solutions, LLC
L0119511445[exp0121][All States][DC, GU, MP, PR, VI]