## INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

**INSTRUCTIONS TO THE RECORDKEEPER** (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

**INSTRUCTIONS TO THE EMPLOYEE**

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

**INSTRUCTIONS TO THE PROPOSED INSURED** (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee, the Employee's Spouse or the Employee's Child.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoi@metlifeservice.com.

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email:
eoi@metlifeservice.com

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer.

These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

MetLife

**Metropolitan Life Insurance Company, New York, NY 10166**

# STATEMENT OF HEALTH FORM

## GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

| Name of Group Customer/Employer/Association | Group Customer # | Reporting Location # |
|---|---|---|
| **Jones Companies, LLC.** | **229751** | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

## INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year 2021

**Term Life Insurance**

- ☐ Basic Life: Indicate amount subject to medical underwriting $N/A
- ☐ Supplemental/Optional Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Spouse[1] Life: Indicate amount subject to medical underwriting $_____
- ☐ Dependent Child Life: Indicate amount subject to medical underwriting $N/A

## EMPLOYEE INFORMATION (To be Completed by the Employee)

| Name of Employee (First, Middle, Last) | Social Security # of Employee |
|---|---|
| | |

## YOUR INFORMATION (To be Completed by the Proposed Insured)

| Name (First, Middle, Last) | Relationship to Employee ☐ Self ☐ Spouse ☐ Child | ☐ Male ☐ Female |
|---|---|---|

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Date of Birth (MM/DD/YYYY) | Daytime Phone # | Home Phone # | Email Address |
|---|---|---|---|
| | | | |

[1] For Vermont and Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

**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)*

Please complete all sections of this form. Incomplete forms will be returned to you.

# HEALTH INFORMATION

## SECTION 1

**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. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.**

Your name _____ Employee's Name _____

Employee's Social Security/Identification # _____

| | Yes | No |
|---|---|---|
| 1. Your height ___ feet ___ inches Your weight ____ pounds | | |
| 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 (month/day/year)? _____ | ☐ | ☐ |
| If "yes", provide Physician's name _____ Telephone: (_____) _____ – _____ | | |
| 4. Are you now, or have you in the past 2 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) (month/day/year) _____ | ☐ | ☐ |
| 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? Indicate reason _____ | ☐ | ☐ |
| 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? Indicate type _____ | ☐ | ☐ |
| b. stroke or circulatory disorder? Indicate type _____ | ☐ | ☐ |
| c. high blood pressure? | ☐ | ☐ |
| d. cancer, Hodgkin's 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? Indicate type _____ | ☐ | ☐ |
| 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? Indicate type _____ | ☐ | ☐ |
| m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____ | ☐ | ☐ |
| 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? Indicate type _____ | ☐ | ☐ |
| 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? Indicate type _____ | ☐ | ☐ |
| u. sleep apnea? Indicate type _____ | ☐ | ☐ |

**After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.**

**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)*

Please complete all sections of this form. Incomplete forms will be returned to you.

**Personal Physician Information**

Personal Physician's Name: _____

Address (Street, City, State, Zip Code): _____ Telephone: (____) ____–____

Date of last visit (MM/DD/YYYY): __/__/____ Reason for visit: _____

**Prescription Information**

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

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Address (Street, City, State, Zip Code): _____

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

**SECTION 2**

**Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1.** 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 here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth __/__/____

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____
Street City State Zip Code

Telephone: (____) ____-____

| Question Number | Condition/Diagnosis | Please list any medication prescribed that you did not already identify in the Prescription Information above. |
|---|---|---|
| | | |
| Date of Diagnosis (Month/Year) | Date of Last Treatment (Month/Year) | Type of Treatment |
| | | |

Treating Health Professional

Physician's Name: _____

Date of last visit: _____ Reason for visit: _____

Address _____

Street City State Zip Code

Telephone: (___) ___-_____

**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)*

## FRAUD WARNINGS

Before signing this Statement of Health 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 to the extent required by applicable law.

**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 Insurance): 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.

**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)*

Please complete all sections of this form. Incomplete forms will be returned to you.

## DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health 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 insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

Sign Here

| Signature of Proposed Insured | Print Name | Date Signed (MM/DD/YYYY) |
|---|---|---|

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

| Signature of Personal Representative | Print Name | Date Signed (MM/DD/YYYY) |
|---|---|---|

Relationship of Personal Representative

# 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.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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 Proposed Insured | | Date Signed (MM/DD/YYYY) |
|---|---|---|
| Print Name | State of Birth | Country of Birth |

If a child proposed for insurance is age 18 or over, the child must sign this Authorization form. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured**. A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Sign Here

| Signature of Personal Representative | Print Name | Date Signed (MM/DD/YYYY) |
|---|---|---|
| Relationship of Personal Representative | | |