

Life Express Order Ticket

Company:  First MetLife Investors Insurance Company  MetLife Investors USA Insurance Company  Metropolitan Life Insurance Company

SECTION I - About the Proposed Insured

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_
State of Residence \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  M  F Social Security No. \_\_\_\_\_
Contact Phone No. \_\_\_\_\_ Preferred Time to Call: From \_\_\_\_\_  AM  PM To \_\_\_\_\_  AM  PM
Language Preference for Telephone Interview  English  Other \_\_\_\_\_

SECTION II - About the Owner

⚠ If Owner is other than Proposed Insured.

Owner Type:  Individual  Trust  Business  Other \_\_\_\_\_
Owner Name \_\_\_\_\_ (include contact name if not an Individual owner)
State of Residence/Domicile \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  M  F SSN/TIN \_\_\_\_\_
Contact Phone No. \_\_\_\_\_ Preferred Time to Call: From \_\_\_\_\_  AM  PM To \_\_\_\_\_  AM  PM

SECTION III - Financial Information

Owner's Earned Annual Income \_\_\_\_\_ Owner's Net Worth \_\_\_\_\_ Source of current and future payments \_\_\_\_\_

SECTION IV - About the Primary Beneficiary

Primary Beneficiary Name First Middle Last Relationship to Insured \_\_\_\_\_

SECTION V - About Existing or Applied for Insurance

⚠ If "YES" to either question in this section, complete and submit any state and company required replacement forms.

Does the Proposed Insured or Owner have any existing or applied for life insurance or annuities with this or any other company?
Proposed Insured  Yes  No Owner  Yes  No
If YES, please provide total amount of existing and applied for Life insurance on the Proposed Insured only \$ \_\_\_\_\_
In connection with this form, has there been, 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?  Yes  No

SECTION VI - About Proposed Coverage

Product Name: \_\_\_\_\_ Face Amount: \_\_\_\_\_
Benefits/Riders: \_\_\_\_\_

Table with 2 columns: Whole Life and Universal Life/Variable Life. Includes options for Dividend Options, Coverage Continuation, Death Benefit Option, and Definition of Life Insurance.

Payment Mode:  Annual  Semi-Annual  Quarterly  Monthly Electronic Payment
 Monthly Electronic Payment per Existing Number \_\_\_\_\_  Other \_\_\_\_\_

Premium \_\_\_\_\_
Special Requests/Additional Information (Include here any requests for alternates/additionals, specific policy date, save age, etc.):

Multiple horizontal lines for entering special requests and additional information.



**SECTION VII - Illustration Certification for UL/VL/Whole Life Products**

Was a sales illustration provided for the life insurance policy as applied for?  Yes  No Rate Class Quoted \_\_\_\_\_

If **YES**, please choose one of the following:

- An illustration was signed and matches the policy applied for. It is included with this Life Express Order Ticket.
- An illustration was shown or provided but is different from the policy applied for. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.
- The sale was made using an illustration with Accelerated Payment. Please indicate number of years \_\_\_\_\_
- An illustration was displayed on a computer screen. The displayed illustration matches the policy applied for but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration displayed on a computer screen included the following information:  
 Gender (as illustrated)  Male  Female  Unisex Age \_\_\_\_\_  
 Rating Class (e.g. Standard Non-smoker) \_\_\_\_\_  Non-smoker  Smoker  
 Product Name \_\_\_\_\_ Face Amount \_\_\_\_\_ Dividend Option (Whole Life Only) \_\_\_\_\_

If **NO**, please choose one of the following:

- Producer certifies that a signed illustration is not required by law.
- No illustration conforming to the policy as applied for was shown or provided prior to or at the time of this Life Express Order Ticket. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

**SECTION VIII - Producer Identification & Certification**

1. What is the purpose of insurance? (Check **ALL** that apply.)

- Estate Planning  Charitable Giving  Qualified Plan  Mortgage Protection  Buy/Sell
- Executive Bonus  Split Dollar  Private Split Dollar  Deferred Compensation  Key Person
- Business Needs - Other  Income Protection  Other \_\_\_\_\_

2. Method used to arrive at the Face Amount Recommendation?

- Profiles Needs Analysis  Human Life Value  GSIB Proposal  Other \_\_\_\_\_

3. Have you completed and attached the required replacement forms?

- Yes  No  N/A

4. Have you attached the Internal Revenue Code Section 1035 form?

- Yes  No  N/A

5. Have the following documents been delivered:

- Privacy Notice  Yes  No Life Insurance Buyer's Guide  Yes  No
- HIV Notice and Consent Form  Yes  No  N/A Temporary Insurance Agreement and Receipt  Yes  No  N/A
- Compensation Disclosure Notice\*  Yes  No  N/A Military Disclosure  Yes  No  N/A
- Debit Authorization Disclosure  Yes  No  N/A Current prospectus for variable products and riders  Yes  No  N/A
- ABR/ADBR Disclosure Statement  Yes  No  N/A

\*Only required for business sold by Agency Distribution Group (MetLife and NEF), MLR and MetLife Auto & Home sales representatives.

6. Did you use only sales material approved for use by the appropriate Company?

- Yes  No

7. Did you see all persons to be insured on the date the Life Express Order Ticket was taken?  Yes  No If **NO**, why not? \_\_\_\_\_

8. Are you related to the Proposed Insured(s)?  Yes  No If **YES**, indicate relationship \_\_\_\_\_

9. Is the Proposed Owner a member of the military services or a dependent of a member of military services? "Member of the military" includes persons in any of the 5 branches of the U.S. Armed Forces or in the Reserve or in the National Guard.  Yes  No

I certify that I have truly and accurately recorded on all parts of this Life Express Order Ticket the information supplied by the Proposed Insured(s) and/or the applicant(s). As noted in question #7 above, I have personally observed the Proposed Insured and the applicant. Apart from any additional comments that I have supplied in the additional information section on the previous page, the Proposed Insured appears to me to be healthy. The purpose of this sale has been discussed with the Owner(s) and I believe that the product recommendations noted in this Life Express Order Ticket are appropriate.

Producer Name (Please Print FULL Name)	Sales Office/ Agency Number/ID	Producer Number/ID	Commission Split % 1st Year	Renewal	Amount of GDC (for MLD only)

**Signatures**

**For Company Use Only**

**Name of Producer** \_\_\_\_\_ ▶ Producer Signature \_\_\_\_\_ Date \_\_\_\_\_

I have personally reviewed this Life Express Order Ticket for appropriateness of sale. The Producer was appropriately licensed and appointed on the date this document was signed.

**Name of Agency Manager or Designee** \_\_\_\_\_ ▶ Agency Manager or Designee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Broker/Dealer or Home Office use only** (Suitability Review of Variable Products) Registered  
 ▶ Principal Signature \_\_\_\_\_ Date \_\_\_\_\_

**Annualized Commissions - Life Independent Producers ONLY** Does the Producer wish to annualize commissions?  Yes  No

If **YES**, signature of Producer's Manager (GA/MGA/BGA) is required. ▶ GA/MGA/BGA Signature \_\_\_\_\_ Date \_\_\_\_\_



## Authorization

**Company** (Check the appropriate ONE.)  Metropolitan Life Insurance Company  General American Life Insurance Company  
The Company indicated in this section is referred to as "**the Company**".  New England Life Insurance Company  MetLife Investors USA Insurance Company  
 MetLife Investors Insurance Company  Metropolitan Tower Life Insurance Company

**This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).**

### For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any pharmacy or pharmacy-related service organization; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
  - personal information and data;
  - entire medical file for the last ten (10) years, including medical information, records and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immunodeficiency Virus (HIV) test results; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

### I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the Company as described in the Company's Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor

who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.

- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. Health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization cannot condition treatment or payment for treatment or other benefits on my signing it.
- **This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company, Privacy Office, PO BOX 489, Warwick, RI 02887-9954 and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.**
- **I have a right to receive a copy of this form.**
- **A photocopy of this form is as valid as the original form.**

## Signatures

Print Name of Proposed Insured

Date of Birth

First

Middle

Last

If Proposed Insured is under 18, the  **Parent** or  **Guardian** is to sign on line for such child.

Signature of Proposed Insured

Date

Signed at City, State

As witness, I attest to having observed all parties sign in my presence.

Witness to Signature

