It’s time to enroll in your

benefits

MetLife

Clackamas County

Group Universal Life

Contents

Please **apply** within your enrollment period. Refer to your enrollment letter for details.

Group Universal Life insurance can help you get more out of life.

Please apply within your 31 days starting the 1st of the month following date of hire.

Dear Clackamas County Employee:

Good news! Your employer has made it possible for you to apply for MetLife Group Universal Life (GUL) insurance, coverage that not only offers protection for the future, but also provides benefits you can take advantage of today.

Did you know that 63% of employees see life insurance as a must-have benefit and 70 of adults whose spouse/partner died prematurely indicated the death had a significant impact on their financial security.[1] What would happen to your family or dependents if something happened to you? Would they be able to pay for housing, tuition and all the other expenses they'll face in the years ahead?

If you have any doubts about your family's financial security, you may wish to consider applying for MetLife GUL insurance. Be sure to act within your eligibility period, which ends 31 days starting the 1st of the month following your hire date. If you don't act within your eligibility period, you will be required to provide evidence of good health if you wish to apply for coverage in the future, and your application will be subject to review and approval by MetLife[2].

GUL offers you the security of life insurance and the ability to contribute to the policy's cash fund which earns interest on a tax-deferred basis.[3]

MetLife GUL gives you all the protection of life insurance but also includes a cash fund that can help you to meet a range of financial needs. If you take advantage of the cash fund, you can contribute premium above the cost of insurance and earn a competitive guaranteed rate of interest of 4%[4], which accrues on a tax-deferred basis. [3]

Coverage levels can be adjusted as your life changes and your coverage is portable if your job changes or you retire.

GUL is as flexible as it is competitively priced[5] and may be more cost effective than you think. You have the freedom to adjust your coverage levels and premiums to reflect life changes, such as having a child or buying a home. It's also portable, so you can take it with you if you change jobs or retire.[6]

You may apply within your eligibility period.

The enclosed brochure and enrollment kit contain valuable tools to help you figure out how much coverage you need, how much premium you may want to contribute to your cash fund and more. But most important, you'll find your enrollment materials, which must be completed and mailed within your eligibility period. If you have questions, feel free to call the MetLife Benefits Line at 1-800-GET-MET8 (1-800-438-6388)**.**

Sincerely,
MetLife Customer Service Department

P.S. Remember, to ensure easy enrollment at a competitive[5] group rate, you must act within 31 days starting the 1st of the month following your hire date.

MetLife

Quotation

The following quotation shows potential policy values for sample ages and policy years on a guaranteed and non-guaranteed basis appropriate to the Group Universal Life ("GUL") plan offered by CLACKAMAS COUNTY.

This quotation is not an illustration. A basic illustration shall be provided to you in connection with the delivery of your certificate of insurance under the GUL plan if you enroll for more than the minimum premium necessary to provide pure death benefit protection.

GUL Benefits:

Life insurance protection

Tax-deferred savings feature

Definition of headings and key terms used in this quotation:

Premium Outlay

The **premium outlay** is equal to your annualized planned premium. Currently, a 2.00% expense charge is deducted directly from planned or unscheduled premium payments. MetLife recoups various expenses associated with your plan's certificates through the aggregate monthly deductions for your plan's certificates. These expenses include state premium taxes and federal taxes. For purposes of the "guaranteed scale" in this quotation, we have assumed a maximum premium expense charge of 10%.

Generally, the premium net of any applicable premium expense charge will go into the cash fund that earns interest and from which monthly deductions are made to cover the cost of the certificate's benefits. If a 2.00% premium expense charge is currently assessed, the Illustrated Scale values assume 98.00% of the premium goes into the cash fund.

Monthly Deductions

The monthly deductions are the sum of the following:

1. The cost of the insurance provided on the covered person.
2. The cost of any additional benefits provided by riders.
3. An administration charge per certificate of $0.00 on the non-guaranteed scale scenarios and $5.00 on the guaranteed scale.

- Monthly deductions are withdrawn from the cash fund for as long as the coverage is in effect and there is adequate cash value.
- This quotation assumes that monthly premium outlay increases over time concurrent to the increase in required monthly deductions.
- Maximum premium limits have been established in this quotation to ensure that the certificate's death benefit is treated as life insurance under the current federal tax law.

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End Of Year

All benefits and values reflected are as of the **end of the certificate year.**

Cash Value

At any time, the certificate may be surrendered for its current **cash value**. The cash value will equal the cash fund, minus any outstanding loans and loan interest. For the purposes of this quotation, no loans or withdrawals have been assumed.

Death Benefit

Your **death benefit** is equal to your face amount plus the value of your cash fund, minus any outstanding loans and loan interest.

What is guaranteed?

- The term **"guaranteed"** refers to the minimum interest rate, maximum cost of insurance rates and maximum expenses guaranteed by MetLife and determined upon issuance of your certificate.
- MetLife guarantees to credit the cash fund with interest at no less than an effective annual yield.
- MetLife guarantees that the cost of insurance rates will never be more than the maximum rates shown in the certificate.
- The "guaranteed" cash value shown is determined based upon these "guaranteed" elements but is also dependent upon the payment of the premiums consistent with the current scale illustrated in the quotation.

Note: The quotation assumes no withdrawals or loans are taken and assumes no changes in benefits over the life of the certificate.

What is non - guaranteed?

- The amounts shown under the **"non-guaranteed"** sections are not guaranteed and reflect investment experience, mortality (death claims) experience, persistency and factors that are subject to change by MetLife. i.e., total company operating expenses, including company overhead.
- If you pay the amounts shown under the 'premium outlay' column, your actual cash value and death benefit may be more or less than the amounts shown under the non-guaranteed rows.
- Changes in coverage amount, or borrowing/withdrawing certificate cash value, will also cause the non-guaranteed values to be more or less than what is shown in this quotation.

Note: This quotation assumes that the currently illustrated non-guaranteed elements will continue unchanged for all years shown. This is not likely to occur, and actual results may be more or less favorable than those shown.

- The amounts under the Illustrated Scale assumption reflect interest rates, cost of insurance rates and expenses which are based on recent historical experience. They may not be the actual assumptions associated with this plan but have been deemed appropriate for this quotation.

MetLife

CLACKAMAS COUNTY

Quotation

Key Assumptions[1,2]

Guaranteed Scale:

- Guaranteed Interest Rate: 4.00%
- Guaranteed Cost of Insurance Table: 100% of '80 CSO
- Front End Load: 10.00%
- Admin Fees: $5.00

Non-Guaranteed Current Scale[3]:

- Non-Guaranteed Interest Rate: 4.00%
- Front End Load: 2.00%
- Admin Fees: $0.00

Issue Age[4]	35
Face Amount[5]	$500,000
Initial Monthly Premium Outlay	$250

Year	Premium Outlay	End of Year Cash Value	
		Guaranteed	Non-Guaranteed
01	$3,000	$1,587	$2,464
02	$3,000	$3,159	$5,026
03	$3,000	$4,707	$7,691
04	$3,000	$6,219	$10,463
05	$3,000	$7,682	$13,346
10	$3,204	$14,684	$29,394
20	$4,248	$22,157	$72,445
30	$6,468	$0	$130,692

Issue Age[4]	45
Face Amount[5]	$500,000
Initial Monthly Premium Outlay	$500

Year	Premium Outlay	End of Year Cash Value	
		Guaranteed	Non-Guaranteed
01	$6,000	$3,034	$4,818
02	$6,000	$5,987	$9,828
03	$6,000	$8,850	$15,039
04	$6,000	$11,600	$20,458
05	$6,000	$14,210	$26,093
10	$6,636	$26,781	$57,637
20	$8,856	$28,337	$137,475
30	$16,932	$0	$220,582

Issue Age[4]	55
Face Amount[5]	$500,000
Initial Monthly Premium Outlay	$1,000

Year	Premium Outlay	End of Year Cash Value	
		Guaranteed	Non-Guaranteed
01	$12,000	$5,345	$9,053
02	$12,000	$10,382	$18,468
03	$12,000	$15,070	$28,259
04	$12,000	$19,356	$38,443
05	$12,000	$23,170	$49,033
10	$13,296	$37,705	$105,525
20	$21,372	$10,836	$226,654
30	$0	$0	$0

[1] Key assumptions are based on values and rates programmed into MetLife systems as of the date the quotation is generated and are subject to change.

[2] This quotation applies a methodology, which assumes you will pay the monthly cost of insurance plus the initial monthly premium outlay stated above in the exhibit demonstrations. Certain plan designs may offer the option of an alternative methodology, which would be described in your plan materials.

[3] This quotation is based on the plan design. If the plan allows for both smoker and non-smoker rates, this quotation has been generated using non-smoker rates. The results may be different if smoker rates were used. If the plan design uses unismoker rates, the results would be the same whether or not a person is a smoker.

[4] The Issue Age is based on the plan's calculation of Age, which increments every plan anniversary.

[5] The Face Amount is the amount of coverage purchased at issuance of the certificate. The amount is assumed to be unchanged in the future.

Aurora GUL Admin Plans (Certificate # 2003): Group Universal Life (GUL) is issued by Metropolitan Life Insurance Company,New York, NY 10166. MetLife's standard Certificate Forms include: Certificate Forms G.9704(2003); G.9704A(2003);NY-G.9704-STOCK and G.9704A-STOCK; OR-G.9704(2003)-2001cso and G.9704A(2003)-2001cso. Coverage may also be provided on MetLife's previous standard Certificate Forms, including: Certificate Forms G.9704; G.9704A ; OR-G.9704-STOCK(OR) and G.9704A-STOCK(OR); OR- G.9704(2003)-1980cso and G.9704A(2003)-1980cso.

Employee Coverage Amounts
Select the level of protection that's best for you:

- Minimum Coverage: $10,000.
- Maximum Coverage: $300,000.
- Coverage is rounded to the next higher $10,000.

Eligibility
Employees are eligible to apply for coverage the first of the month following date of hire. To be eligible for any amount of coverage, you must be "Actively at Work" on the effective date of coverage.

Dependent Coverage Amounts
Employee must apply for GUL coverage in order to apply for spouse/domestic partner. For child coverage, Employee must apply for coverage. Your spouse and eligible child(ren) must not be confined, receiving, or awaiting a response regarding an application for disability benefits from any source or hospitalized on the date their coverage is scheduled to become effective. If they are confined, receiving, or awaiting a response regarding an application for disability benefits from any source or hospitalized on such date, then please see below under "About Your Coverage Effective Date."

Coverage for Your Spouse/Domestic Partner[7]

- Term Life – From $10,000 to $300,000, in $10,000 increments.
- If your spouse/domestic partner is also an employee of Clackamas County, your spouse/domestic partner can either apply for employee coverage or spouse/domestic partner coverage, but not both.
- Please be prepared to provide the spouse or partner's Social Security Number.

Coverage for Your Children[7]
Term Life Rider- $2,000, $4,000, $6,000, $8,000 or $10,000

- Coverage is available for children from age 14 days to 26 years.

Cash Fund Options
GUL lets you set aside premium above the cost of insurance in its tax-deferred[3] cash fund which will earn a guaranteed minimum interest rate of 4%.[4] You can select a certain dollar amount to contribute through payroll deduction. This amount will be automatically put into the cash fund and will earn a guaranteed minimum interest rate.

GUL's cash fund can be one place to set aside extra funds and watch your money grow on a tax-deferred basis.[3] To contribute to the cash fund, simply complete the appropriate section on your enrollment form. For more information and to see how your money can grow tax-deferred, please refer to the Understanding Your Group Universal Life's (GUL) Cash Fund section.

How to access the Cash Fund:
You may access your money through loans and withdrawals[8], provided there is adequate cash value in your fund. You can take only one loan at a time, the minimum being $250. You can make one withdrawal per year provided you have adequate cash value in your cash fund, each for a minimum of $250. There may be fees associated with some withdrawals and some withdrawals may have tax implications.[8]

Your cost of insurance is provided at competitive[5] group rates . Paying is easier, and you won't have to worry about missing payments, since it's done through automatic payroll deductions.

Employee and Spouse/Domestic Partner Monthly Rates - Includes Waiver of Premium (Employee Only)

Use the rates below in the enclosed worksheet to determine your total monthly premium. Current rates (cost per $1,000 of coverage per month) are based on your age as of December 31st of the current year. Spouse/Domestic Partner rates are based on the spouse/domestic partner's age as of December 31st of the current year. By completing this worksheet, you can figure out how much your coverage will cost you each month. You may also factor in your expected monthly cash fund contribution.

Non-Smoker

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*
Employee/ Spouse/Domestic Partner rate per $1,000 of coverage	$.044	$.048	$.062	$.096	$.164	$.270	$.424	$.640	$1.186

Smoker**

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*
Employee/ Spouse/Domestic Partner rate per $1,000 of coverage	$.066	$.074	$.102	$.150	$.224	$.330	$.518	$.798	$1.270

** A smoker is anyone who has smoked or used a tobacco product during the past 1 year.

Child Flat Monthly Rate: $.060 per $1,000 of coverage (covers all eligible children)

For example, for $100,000 of GUL coverage the current monthly premium for a 30-year-old would be 100 times $.048 per $1,000, for a 40-year-old it would be 100 times $.096 per $1,000 and for a 50-year-old it would be 100 times $.270 per $1,000.

Changes in Your Cost of Insurance Rates/Premium

The cost of insurance rates varies depending upon the amount of coverage, your age and benefits selected. Additionally, these rates will increase as you get older. Your current rates are guaranteed until the policy renewal date. At the renewal date, rates will be recalculated and may change.[10] Rates will also change and can increase if you leave your employer and choose to continue your coverage.

For more complete information, please contact the MetLife Benefits Line at 1-800-GET-MET8 (1-800-438-6388).

About Your Coverage Effective Date
You must be Actively at Work on the date your coverage is scheduled to become effective. Your spouse/domestic partner and eligible child(ren) must not be home, or hospital confined or receiving or applying to receive disability benefits from any source when their coverage is scheduled to become effective.

Coverage will become effective on the first of the month following the receipt of your completed application for all requests that do not require additional medical information. A request for an amount that requires additional medical information and is not approved by the date listed above will not be effective until the later of the date the notice is received that MetLife has approved the coverage or increase if you meet Actively at Work requirements on that date, or the date that Actively at Work requirements are met after MetLife has approved the coverage or increase. The coverage for your spouse/domestic partner and eligible child(ren) will take effect on the date they are no longer confined, receiving, or applying for disability benefits from any source or hospitalized. Your coverage must be in effect for your spouse/domestic partner's and eligible children's coverage to take effect.

Once you have enrolled and have elected to contribute to the Cash Fund, you will receive an Illustration.

By completing this worksheet, you can determine how much your coverage will cost. You should also factor in your monthly cash fund contribution, if applicable.

Section 1 – Employee Coverage

A. AMOUNT OF COVERAGE – You may select coverage from $10,000 to $300,000 in increments of $10,000.

B. MONTHLY COST OF COVERAGE – Multiply cost per $1,000 of (see Insurance Rate Sheet) by the number of $1,000 units you've selected (for example, $70,000 = 70 units)

Amount of Coverage			**# of $1,000 Unit of Coverage**		**Your cost per $1,000 of coverage (see Rate Sheet)**		**MONTHLY COST OF INSURANCE**	
$	÷ $1,000 =			**X**	**$**	**=**	**$**	**1**
$70,000			70		$0.062 (example age 36 non-smoker		$4.34	

C. CASH FUND CONTRIBUTIONS – If you plan to contribute to your cash fund, add the amount you plan to contribute each month (for example, $25, $50, $100) …….……... **$** **2**

TOTAL MONTHLY COST OF EMPLOYEE COVERAGE (1+2) …… **$** **3**

Section 2 – Dependent Coverage

A. SPOUSE/ DOMESTIC PARTNER COVERAGE – You may select coverage from $10,000 to $300,000 in increments of $10,000. Spouse/domestic partner coverage. To calculate cost of spouse/domestic partner coverage follow direction in Section 1, Item B.

B. **MONTHLY COST OF COVERAGE**-Multiply cost per $1,000 of (see Insurance Rate Sheet) by the number of $1,000 units you've selected (for example, $70,000 = 70 units)

Amount of Coverage			**# of $1,000 Unit of Coverage**		**Your cost per $1,000 of coverage (see Rate Sheet)**		**MONTHLY COST OF INSURANCE**	
$	÷ $1,000 =			**X**	**$**	**=**	**$**	**4**
$70,000			70		$0.062 (example age 36 non-smoker)		$3.72	

C. CHILD(REN) COVERAGE – Select coverage from $2,000 to $10,000 in increments of $2,000, regardless of the number of children.
you have and fill in the monthly cost of coverage (see Insurance Rate Sheet) ……..……...… **$** **5**

TOTAL MONTHLY COST OF DEPENDENT COVERAGE (4+5) …… **$** **6**

Section 3: Total Monthly Premium

To find your Total Monthly Premium for all covered individuals, add Total cost of Employee Coverage and Dependent Coverage

TOTAL EXPECTED MONTHLY PREMIUM (3+6) ……..... **$** **7**

In addition to life insurance protection, Clackamas County employees who apply for Group Universal Life will have available to them a range of valuable plan features and enhancements:

Will Preparation Services[10] – ***helping to ensure your decisions are carried out as you wish.***
Like life insurance, a carefully prepared Will (Simple, Complex or Living) along with a Power of Attorney are important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property.

By enrolling for GUL Life coverage, you will have face-to-face access to MetLife Legal Plans' network of over 18,000 participating plan attorneys to prepare or update a will, living will or power of attorney for you and your spouse/domestic partner at no cost.* Call 1-800-821-6400 and a Client Representative will assist you.

*You also have the flexibility of using an attorney who is not participating in the MetLife Legal Plans' network and being reimbursed for covered services according to a set fee schedule. In that case you will be responsible for any attorney's fees that exceed the reimbursed amount.

Estate Resolution Services[SM] (ERS)[11] –*settling a loved one's estate with confidence.*
This valuable service offered through MetLife Legal Plans provides executors/administrators of both your and your spouse's/domestic partner's estates with access to the services of a participating MetLife Legal Plans attorney to handle probating the deceased's estate. You can feel confident that the legal assistance provided to the executor/administrator will help alleviate the administrative burden; there is no cost for services provided by a network attorney. Beneficiaries can also consult with a network attorney to discuss general questions regarding the probate process. Call 1-800-821-6400 and a Client Representative will assist you.

Waiver of Premium – You may be eligible to have your insurance premium waived until you reach age 65, die or recover from your disability, whichever is sooner, should you become unable to work due to total disability. The total disability must begin before age 60, and your waiver will begin after you have satisfied a 9-month waiting period. The Waiver of Premium will end on the earliest of your turning age 65/70, death or recovery. Please note that this benefit is available after you have participated in the GUL Plan for one year and it is only available for employee (not spouse/domestic partner) coverage. The one-year requirement applies to new participants in the plan.

Accelerated Benefits Option (ABO)[12] – The Accelerated Death Benefit due to Terminal Illness Rider pays 50% of an insured's Life Insurance proceeds to a maximum of $250,000 (with the balance payable upon final claim) in most states if the insured becomes terminally ill. Conditions and restrictions may apply. Any outstanding loans will reduce the cash value and death benefit. The Accelerated Benefit Option is also available to spouses insured under Dependent Life insurance plans. This option is not available for dependent child coverage.

Total Control Account® (TCA)[13]– ***reducing the pressure of immediate financial decisions.*** MetLife's Total Control Account® provides your loved ones with a safe and convenient way to manage the proceeds of a life or accident policy for claim payments of $5,000 or more, backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company. Your beneficiaries have the convenience of immediate access to any or all of their proceeds through an interest-bearing account with unlimited draft-writing privileges. The Total Control Account gives beneficiaries time to decide what to do with their proceeds, which can be very helpful to them during a difficult time.

Special Events – If you get married/divorced, have a baby/adopt a child or purchase a home, you can increase your coverage up to $50,000 without evidence of insurability, subject to the coverage eligibility guidelines and program limits, provided you request the change within 31 days of the special event.

Beneficiary Claim Assistance[14]– *support and guidance when beneficiaries need it most.*
MetLife's Delivering The Promise® is a service designed to provide beneficiaries with the support and assistance they need during an especially difficult time. Services include assistance filing life insurance claims and consultation to help with the financial details and questions that arise upon the loss of a loved one. MetLife has arranged for specially trained third-party financial professionals to be able to answer questions and provide the guidance you need to help make the right decisions to protect your financial future.

Portability - *So you can keep your coverage even if you leave your current employer.*
GUL: If you retire or leave your company, you can continue your coverage. Rates may change but are generally lower than the rates available under a conversion option. Coverage may reduce at age 70 to the lesser of your current amount and five times the amount in your cash fund, but at no time can your coverage after age 70 exceed your current face amount. The minimum amount of coverage you may elect to port is $10,000. Like term insurance, you also have the option to convert your coverage to permanent individual life insurance protection.

How to Apply:

Complete and sign the enclosed enrollment form and mail in the provided postage-paid envelope.

If you have questions, please call a MetLife Customer Service Consultant at 1 800 GET-MET8 (1-800-438-6388).

Although current rates may change over time, your GUL rates will never be more than the maximum guaranteed monthly rates shown in your certificate. Sample ages of your maximum guaranteed monthly rate are shown in the chart below.

Sample Maximum Guaranteed Employee Monthly Rate*

Age	30	35	40	45	50	55	60	65	70*
Maximum employee rate per $1,000 of coverage	$0.146	$0.181	$0.263	$0.395	$0.585	$0.918	$1.411	$2.246	$3.515

* For Maximum Guaranteed Employee Monthly Rate by specific age, please refer to your plan certificate.

For example, for $100,000 of GUL coverage the guaranteed maximum monthly premium for a 30-year-old would be 100 times $0.146 per $1,000, for a 40-year-old it would be 100 times $0.263 per $1,000 and for a 50-year-old it would be 100 times $0.585 per $1,000.

What's Not Covered?

Like most insurance plans, this plan has exclusions. Group Universal Life Insurance does not provide payment of benefits for death caused by suicide within the first two years (one year for group policies issued in Missouri, North Dakota, and Colorado) of the effective date of the certificate or an increase in coverage. This exclusionary period is one year for residents of Missouri and North Dakota. If the group policy was issued in Massachusetts, the suicide exclusion does not apply to dependent life coverage. The suicide exclusion does not apply to residents of Washington, or to individuals covered under a group policy issued in Washington.

1 MetLife 20th Annual U.S. Employee Benefit Trends Study 2022

2 All applications for coverage are subject to review and approval by MetLife.] [If you choose to apply for increased coverage, the increase may be subject to underwriting. MetLife will review your information and evaluate your request for coverage based upon your answers to the health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage. Coverage will be effective in accordance with the applicable policy and certificate after approval by MetLife. Only applicants who reside in a US state, the District of Columbia, or Guam, Northern Mariana Islands, Puerto Rico, or US Virgin Islands are allowed to complete their SOH form online (where available). Otherwise, applicants will be provided with a paper SOH form. Individuals residing outside of the US or in certain US territories must be on US payroll and be approved by MetLife before being provided with an SOH form.

3 Earnings within your GUL coverage grow income tax free while the policy stays in force. Please consider your time horizon, tax rates, and the effect of fees and expenses, including any premium expense charge, when evaluating the benefit of GUL tax deferral. See your Certificate for complete information.

4 Guarantees are subject to the financial strength and claims-paying ability of Metropolitan Life Insurance Company.

5 Cost of insurance rates are determined using methodologies that vary by company. These rates can vary and will generally increase with age. Rates for active employees may be different than those available to terminated or retired employees. It's important to look at all factors when evaluating the overall competitiveness of rates and the value of life insurance coverage.

6 To the maturity age specified in your certificate. If your plan sponsor replaces MetLife GUL with another group life insurance plan or otherwise terminates the MetLife group policy, your coverage will also be terminated, even after retirement Rates will increase if you leave your employer for reasons other than retirement and choose to continue your coverage. If you have ported or otherwise continued your coverage after retirement or separation from employment and the plan sponsor later terminates the group policy, cost of insurance rates may increase as a result of such termination.

7 For New York residents, dependent coverage cannot exceed the amount the employee is eligible to elect.

8 In general, participants may withdraw cash value equal to premiums paid without tax consequences. However, if the funding of the certificate exceeds certain limits, it will become a "modified endowment contract" (MEC) and become subject to "earnings first" taxation on withdrawals and loans. An additional 10% penalty for withdrawals and loans taken before age 59½ will also generally apply to MECs. We will notify you if a contribution would cause your certificate to become a MEC. Withdrawals and loans will reduce the death benefit and cash value and thereby diminish the ability of the cash value to serve as a source of funding for cost of insurance charges, which increase as you age. Withdrawals are subject to an administrative fee of 2% of the amount withdrawn, not to exceed $25. Outstanding loan amounts do not participate in the interest

credited to the interest-bearing account and can have a permanent effect on certificate values and benefits. Upon surrender, lapse, or case termination, including those circumstances where termination of the group contract results in termination of individual certificates/policies, loans become withdrawals and may become taxable to the certificate owner.

9 The GUL group contract provides MetLife with the right to adjust the rates and/or the rate guarantee period should overall group participation change significantly.

10 Will Preparation is offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, Rhode Island. For New York sitused or principally located cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.

11 Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company Warwick, Rhode Island. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

12 The ABO benefits are intended to qualify for favorable federal tax treatment in which case the benefits will not be 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 ABO 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 ABO benefits will have on public assistance eligibility for you, your spouse, or your family.

13 MetLife administers the Transition Solutions program and has arranged to have specially trained third-party financial professionals offer financial education. The financial professionals providing financial education are not affiliated with MetLife but are providing the program under a service provider contract.

Group Universal Life (GUL) is issued by Metropolitan Life Insurance Company, New York, NY 10166. Certificate Form G.9704(2009) G.9704A(2009).

Coverage and benefits are subject to the terms and conditions of the contract between MetLife and your employer. Specific details regarding these provisions can be found in the booklet certificate. If you have additional questions regarding the Group Universal Life Insurance Program underwritten by MetLife, please contact MetLife at 1 800 GET-MET8 (1-800- 438-6388).

Nothing in these materials is intended to be advice for a particular situation or individual. Please consult with your own advisors for such advice. Like most insurance policies, MetLife GUL contains exclusions, limitations, and terms for keeping it in force. MetLife can provide you with costs and complete details.

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Clackamas County	**74414**			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	Date of Hire (MM/DD/YYYY)	

☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must complete this Hospitalization question for GUL, Dependent Spouse/Domestic Partner Term Life and Dependent Child Term Life.

Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?

Employee	Spouse/Domestic Partner	Child(ren)
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If a Proposed Insured has been Hospitalized within the last 90 days a Statement of Health must be completed for the person to whom the "yes" applies. **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.

► If you are enrolling during the initial enrollment period, you must complete the Health Information section of this form and the enclosed Authorization form:
- If you are enrolling for more than $60,000 of GUL Insurance
- If you are enrolling for more than $20,000 of Dependent Spouse/Domestic Partner Term Life Insurance

► If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Group Universal Life (GUL) Insurance

Note: A reduction in coverage may result in an irreversible Modified Endowment Contract (MEC) status and unfavorable tax treatment of withdrawals and loans, depending on circumstances. If you are planning to reduce your GUL coverage and do not want your certificate to become a MEC, please call 1-800-523-2894 to find out whether this will result in unfavorable tax consequences.

☐ GUL [1]

Enter a multiple of $10,000 up to a maximum of $300,000 _____

Monthly Contribution to the GUL Cash Fund: ☐ $0 ☐ $10 ☐ $15 ☐ $25 ☐ Other: _____ ☐ Discontinue

Term Life Insurance

☐ Dependent Spouse/Domestic Partner [2] Term Life [1, 3]

Enter a multiple of $10,000 up to a maximum of $300,000 _____

☐ Dependent Child Life [3]

☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000

[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.

[2] Domestic Partner 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. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest.

[3] Amounts will be subject to state limits, if applicable.

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, make a copy for your records and return the original to
MetLife Recordkeeping Center, P. O. Box 14402, Lexington, KY 40512-4402.
If you have any questions, call the MetLife Benefits Line at 1-800-523-2894.

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Social Security #

Name(s) of your Child(ren) (First, Middle, Last) | Date of Birth (MM/DD/YYYY)

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

Smoking Status Information

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 years? Employee ☐ Yes ☐ No Spouse/Domestic Partner ☐ Yes ☐ No

If you are changing smoking status
Status is changing from: ☐ Smoker to Non-Smoker ☐ Non-Smoker to Smoker Change is for: ☐ Employee ☐ Spouse/Domestic Partner

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)*

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.

Your height ____ feet ____ inches Spouse/Domestic Partner height ____ feet ____ inches

Your weight ____ pounds Spouse/Domestic Partner weight ____ pounds

	Employee	Spouse/ Domestic Partner
1. 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	☐Yes ☐No
2. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐Yes ☐No	☐Yes ☐No
3. 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.	☐Yes ☐No	☐Yes ☐No
4. **For CT residents, 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?	☐Yes ☐No	☐Yes ☐No
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐Yes ☐No	☐Yes ☐No
b. stroke or circulatory disorder?	☐Yes ☐No	☐Yes ☐No
c. high blood pressure?	☐Yes ☐No	☐Yes ☐No
d. cancer, Hodgkin's disease, lymphoma or tumors?	☐Yes ☐No	☐Yes ☐No
e. diabetes?	☐Yes ☐No	☐Yes ☐No
f. asthma, COPD, emphysema, or other lung disease	☐Yes ☐No	☐Yes ☐No

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

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 enrollment 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New York (only applies to Accident and Health 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)*

BENEFICIARY DESIGNATION FOR EMPLOYEE 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. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ 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%

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)*

DECLARATIONS AND SIGNATURE

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 insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **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.
4. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	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)*

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, LLC ("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;
  - 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, 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 Employee		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Sign Here

Signature of Spouse/Domestic Partner		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

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/Domestic Partner 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@metlife.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@metlife.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.

STATEMENT OF HEALTH FORM

Metropolitan Life Insurance Company, New York, NY 10166

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association		Group Customer #	Reporting Location #
Street Address	City	State	Zip Code

INSURANCE INFORMATION (To be Completed by the Recordkeeper)

Enrollment year

Group Universal Life (GUL) Insurance

☐ GUL: Indicate amount subject to medical underwriting $_____

Term Life Insurance

☐ Dependent Spouse/Domestic Partner Life: Indicate amount subject to medical underwriting $_____

☐ Dependent Child Life: Indicate amount subject to medical underwriting $_____

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/Domestic Partner ☐ Child
Street Address	City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address

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 11p, 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? (This does not include AIDS, ARC or the HIV infection.) Indicate type _____	☐	☐
	f. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated	☐	☐
	g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
	h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
	i. memory loss? Indicate type _____	☐	☐
	j. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	☐	☐
	k. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
	l. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
	m. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
	n. thyroid or other gland disorder? Indicate type _____	☐	☐
	o. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	☐	☐
	p. 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 11p.

Personal Physician Information

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

Approximate last visit (MM/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: (____) ____–____

Medication: _____ Condition/Diagnosis: _____

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

☐ 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 11p 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: _____ Telephone: (____) ____-____		
Approximate last visit: _____ Reason for visit: _____		

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: _____ Telephone: (____) ____-____		
Approximate last visit: _____ Reason for visit: _____		

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: _____ Telephone: (___) -		
Approximate last visit: _____ Reason for visit: _____		

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 DEC** *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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

New York (only applies to Accident and Health 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, LLC ("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;
  - 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, 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		

MetLife
Metropolitan Life Insurance Company, New York, NY

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at *866-692-6901 or go to its website at www.mib.com to request disclosure online. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184- 8734.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan General Insurance Company
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard 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.

SECTION 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, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice, "you" refers to these individuals.

SECTION 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.

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

SECTION 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
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

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, LLC ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 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

SECTION 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

SECTION 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.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. 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.

SECTION 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. A detailed notice shall be furnished to you upon request. 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.