

Group Universal Life (GUL) Insurance

Get More Out of Your Life Insurance



MetLife



If my life insurance could do more for me today, and still provide protection for tomorrow.





Right now you have the opportunity to enroll in a life insurance plan that not only helps you to prepare for tomorrow, but can actually help you live better today.

MetLife Group Universal Life (GUL) is more than a basic life insurance product—it is a flexible, valuable alternative for your life insurance needs. In addition to providing reliable protection for your family, GUL also offers the opportunity to contribute to a tax-deferred savings feature that can help you meet your short or long-term financial goals.

Life insurance is one of the most important tools that you have to protect your dependants' financial future. Whether you already have some life insurance or are just starting to think about it, take a minute to see how MetLife's GUL insurance fits into your financial plan.



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Enrollment Form (can be found in center of booklet for easy removal)

Please enroll within your enrollment period. Refer to your enrollment letter for details.

Group Universal Life Can Help You Get More Out Of Life

You must enroll within your 31 day eligibility period.

Dear Clackamas County Employee:

Good news! Your employer has made it possible for you to enroll in MetLife Group Universal Life Insurance, a plan that not only offers protection for the future, but can also help you to live better today.

Research shows that most Americans don't have enough life insurance,¹ and that without adequate coverage the premature death of a provider can have a major impact on a family's finances. 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, take this special opportunity to enroll in MetLife Group Universal Life. Be sure to act within your eligibility period, which ends 31 days from your date of hire. If you don't act within your eligibility period, you will have to provide evidence of good health, and coverage will be subject to approval by MetLife.

Group Universal Life offers you the security of life insurance and the ability to contribute to a cash fund which earns interest on a tax-deferred basis.

MetLife Group Universal Life 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 cash and earn a competitive guaranteed rate of interest², which accrues on a tax-deferred basis.

Adjust your coverage levels as your life changes and take your coverage with you if your job changes.

Group Universal Life is as flexible as it is competitively priced. 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 portable, so you can take it with you if you change jobs or retire.³

So don't delay. Enroll 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 cash you may want to contribute to your cash fund and more. But most important, you'll find your enrollment materials, which must be completed at and mailed within your eligibility period. For fastest, easiest completion, you can enroll online. If you have questions, feel free to call the MetLife Benefits Line at **1 800 GET-MET 8** (1-800-438-6388).

Sincerely,

MetLife Customer Service Department

P.S. Remember, to ensure easy enrollment at a competitive group rate, you must act within 31 days of your eligibility period.

¹ Fifth Annual MetLife Study of Employee Benefit Trends, 2009. "Underinsured" is defined as having life insurance coverage less than three times annual household income.

² All guarantees are subject to the financial strength and claims paying ability of Metropolitan Life Insurance Company

³ To age 95. In some cases, if your employer replaces the MetLife GUL group contract with group life insurance from another insurer or otherwise terminates the MetLife GUL group contract, your MetLife GUL coverage may also be terminated, even after separation from employment or in retirement.

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.

Like most group life insurance policies, MetLife group policies contain certain exclusions, limitations, exceptions, reductions, waiting periods and terms for keeping them in force. Please contact MetLife for costs and complete details.

Understanding Your Group Universal Life's (GUL) Cash fund

Get More Out of Your Life Insurance

Did you know that, in addition to life insurance protection, your Group Universal Life (GUL) insurance coverage allows you to build cash value by making contributions to a cash fund? The cash fund is what makes GUL coverage different from other life insurance products. When you contribute to GUL's cash fund, you can benefit from tax advantages. You'll also benefit from a great range of options.

Keep More Money for Yourself

The money you contribute to the cash fund earns a competitive interest rate that is guaranteed not to fall below a certain minimum level. Your interest also accrues on a tax-deferred basis.

Flexible Options for Today and Tomorrow

GUL coverage, combined with the cash fund, offers great options that can help you reach short- and long-term financial security and prepare for life's challenges. With the cash fund you can:

- Choose the amount you wish to contribute on a regular basis through payroll deduction and/or a lump-sum contribution.
- Access your cash fund – for any reason – through loans and withdrawals¹. There are no penalties for withdrawal, and there is no time limit on loan repayment.
- At retirement, use your cash fund to pay your life insurance coverage, buy an annuity, elect paid-up insurance, or receive a lump-sum payment. What's more, your beneficiary(ies) will receive both your life insurance benefit and any money in your cash fund generally income tax-free.

Life Insurance Coverage That Meets Your Changing Needs

As you consider the advantages of GUL's cash fund, take a moment to think about your GUL coverage – is it keeping pace with your changing needs? Consider life events, such as:

- Marriage/Divorce
- Sending a child to college
- Birth of a child
- Care of an elderly family member
- Purchase of a new home

Do any of these situations pertain to you? If so, it may be time to “step up” your life insurance coverage². To determine how much life insurance you need to protect your family's financial security, access the MetLife Life Insurance Calculator at www.metlifeeasier.net/na.

If you wish to contribute to the GUL Cash Fund and make monthly contributions, be sure to complete the appropriate section on your Enrollment Form.

Like most group insurance policies, MetLife group policies contain certain exclusions, limitations, exceptions, reductions, waiting periods and terms for keeping them in force. Please contact MetLife for costs and complete details.

¹ Loans and withdrawals will reduce the death benefit and cash value. Withdrawals may be subject to taxation if the amount of the withdrawal exceeds the total premiums paid, which includes the cost of insurance and cash fund contributions.

² Subject to plan provisions. All applications are subject to approval by MetLife.

Plan Summary For Employees of: Clackamas County

Employee Coverage Amounts

Select the level of protection that's best for you.

- Minimum Coverage: \$10,000.
- Maximum Coverage: \$300,000.

Eligibility

Employees are eligible to enroll for coverage after 60 days of continuous employment. To be eligible for any amount of coverage, you must be "Actively at Work" on the effective date of coverage.

Dependent Coverage Amounts

Select coverage for your spouse and child(ren). Employee must enroll for GUL coverage in order to enroll for spouse and/or child coverage and your spouse and eligible child(ren) must be performing their Normal Activities when coverage becomes effective.

Coverage for Your Spouse¹

- Term Life – From \$10,000 to \$300,000, in \$10,000 increments.
- If your spouse is also an employee of Clackamas County, your spouse can either enroll for employee coverage or spouse coverage, but not both.

Coverage for Your Children

Term Life Rider—\$2,000 to \$10,000, in \$2,000 increments.

- Coverage is available for children from age 14 days to 21 years (or 25 years if enrolled at an accredited college or university)

Cash Fund Options

Group Universal Life is life insurance that lets you set aside money in a tax-deferred cash fund which will earn a competitive rate of interest. You select a certain dollar amount to contribute through payroll deduction above the cost of your life insurance coverage. This amount will be automatically and conveniently put into the cash fund and will earn a competitive interest rate.

GUL's cash fund is an attractive place to set aside extra funds and watch your money grow on a tax-deferred basis. 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 see the enclosed Cash Fund Facts sheet.

Your cost of insurance is provided at affordable 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 Monthly Rates
Includes Waiver of Premium (Employee Only)**

Use the rates below in the enclosed worksheet to determine your total monthly premium. Rates (cost per \$1,000 of coverage per month) are based on your age as of December 31st of the current year. Spouse rates are based on spouse'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 and Spouse rate per \$1,000 of coverage	\$.055	.061	.078	.120	.205	.337	.530	.801	1.483

Smoker**

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69*
Employee and Spouse rate per \$1,000 of coverage	\$.082	.093	.128	.186	.279	.413	.648	.996	1.586

Child Flat Monthly Rate: \$.074 per \$1,000 of coverage (covers all eligible children).

For more complete information, please contact the MetLife Benefits Line at 1 800 GET-MET 8 (1-800-438-6388).

*For rates over age 69, call the MetLife Benefits Line at 1 800 GET-MET 8 (1-800-438-6388).

** A smoker is anyone who has smoked or used a tobacco product during the past 12 months.

There is an additional monthly administration charge of \$2.00.

By completing this worksheet, you can determine how much your coverage will cost. You may also factor in your expected monthly Cash Fund contribution.

Section 1 – Employee Coverage

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

A. 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 \$ <input style="width: 100px;" type="text"/> \$70,000	÷	\$1,000	=	# of \$1,000 Unit of Coverage <input style="width: 50px;" type="text"/> 70	X	Your cost per \$1,000 of coverage (see Rate Sheet) \$ <input style="width: 80px;" type="text"/> \$0.078 (example age 36 non-smoker)	=	MONTHLY COST OF INSURANCE \$ <input style="width: 80px;" type="text"/> \$5.46	1
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B. 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 COVERAGE – You may select coverage from \$10,000 to \$300,000 in increments of \$10,000. Spouse coverage may not exceed 2X your base annual salary. To calculate cost of spouse coverage follow the directions in Section 1, Item B.

Amount of Coverage \$ <input style="width: 100px;" type="text"/> \$60,000	÷	\$1,000	=	# of \$1,000 Unit of Coverage <input style="width: 50px;" type="text"/> 60	X	Your cost per \$1,000 of coverage (see Rate Sheet) \$ <input style="width: 80px;" type="text"/> \$0.078	=	MONTHLY COST OF INSURANCE \$ <input style="width: 80px;" type="text"/> \$4.68	4
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B. CHILD(REN) COVERAGE – Select coverage from \$2,000 to \$10,000, in increments of \$2,000 for each child, regardless of the number of children you have, 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 enroll for Group Universal Life will enjoy a range of valuable plan features and enhancements:

Waiver of Premiums – You may be eligible to waive your insurance premium until you reach age 65, die or recover from your disability, whichever is sooner, should you become unable to work due to total disability². 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, 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 to you. This one-year requirement applies to new participants in the plan.

Accelerated Benefits Option³(ABO) – You can receive up to 50% of your Life insurance proceeds to a maximum of \$250,000 in the event that you become terminally ill and are diagnosed with less than 6 months to live. This can go a long way toward helping your family meet medical and other related expenses at this difficult time. 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) – The Total Control Account[®] settlement option 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. They'll have the convenience of immediate access to any or all of their proceeds, through an interest bearing account with unlimited check-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.

MetLife Advice* for Beneficiaries—Delivering The Promise[®] - MetLife Advice for Beneficiaries—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 Advice Specialists are Financial Services Representatives of MetLife or New England Financial, a MetLife company.*

Special Events – If you get married/divorced, have a baby/adopt a child or purchase a home, you can increase your coverage by a \$10,000 increment 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.

If you have questions, please call a MetLife Customer Service Consultant at **1 800 GET-MET 8** (1-800-438-6388).

¹For Texas and New York residents, dependent coverage cannot exceed the amount of employee coverage.

²Total disability or totally disabled means your inability to do your job and any other job for which you are fit by education, training or experience, due to injury or sickness.

³ The Accelerated Benefits Option (ABO) is subject to state regulation and generally receives favorable federal income tax treatment. You are advised to consult with a legal advisor about your own circumstances. You are advised to consult with a legal advisor concerning the effect that receipt of ABO benefits will have on other benefits such as benefits from public assistance programs.

Life coverage are provided under a group insurance policy (Policy Form GPNP99/G2130-S) issued to your employer by MetLife. Life coverage under your employer's plan terminates when your employment ceases, when your Life contributions cease, or upon termination of the group contract. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent or when a dependent spouse reaches age 70. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

ENROLLMENT FORM FOR GROUP UNIVERSAL LIFE INSURANCE BENEFITS

SECTION TO BE COMPLETED BY METLIFE VOLUNTARY BENEFITS AND EMPLOYEE (shaded areas are for MetLife use only)

Name of Employer Clackamas County		Group Report No. 74414	Sub Division	Branch
Employer's Street Address 2051 Kaen Road		City Oregon City	State OR	Zip Code 97045
Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) \$	Employee's Occupation		Coverage Effective Date (Mo./Day/Yr.)
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		Hours Worked Per Week		Pay Frequency <input type="checkbox"/> Monthly
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire/First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____				

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address Street City	State Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
E-mail Address	Phone No.(include area code)		

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage: Check box if coverage is desired;

Employee Coverage

- Group Universal Life (GUL):
You may elect a multiple of \$10,000 up to a maximum of \$300,000.
Amount Requested: \$ _____
Extra Monthly Contribution to the GUL Cash Fund \$10 \$15 \$25 Other \$ _____

Dependent Spouse/Domestic Partner and Child Coverage

- Group Universal Life
Spouse Group Universal Life Amount*:
You may elect a multiple of \$10,000 up to a maximum of \$300,000.
Amount Requested: \$ _____
Child(ren) Term Amount*:
 \$2,000 \$4,000 \$6,000 \$8,000 \$10,000
(**Note:** Each child is insured for the same amount of coverage regardless of number.)

*Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse/Domestic Partner or Child), complete the following:

For Domestic Partner coverage, you must complete and attach a Domestic Partner Declaration or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available. Check the applicable box:

- My Domestic Partner Declaration is attached.
- My Domestic Partner and I are registered as domestic partners or members of a civil union as stated above.

Number of dependents (including spouse/domestic partner) _____

Name of Spouse/Domestic Partner (Last, First, MI)	Date of Birth	Sex (M/F)	SSN#
_____	_____	_____	_____
Name(s) of Child(ren) (Last, First, MI)	Date of Birth	Sex (M/F)	Is child a full-time student?
_____	_____	_____	<input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> Yes
_____	_____	_____	<input type="checkbox"/> Yes

Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 1 years from the date of this enrollment form?	Employee	Spouse/Domestic Partner
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you been Hospitalized (as defined below) during the 90 days Preceding the date of this enrollment form?	Employee	Spouse/Domestic Partner	Child(ren)
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

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.

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Medical Information - For Employee Life Insurance Amounts in Excess of \$50,000 up to \$300,000, or Dependent Spouse/Domestic Partner Life Insurance Amounts in Excess of \$20,000 up to \$300,000, Answer The Following Questions.

Please complete all questions below. Omitted information will cause delays. In the Medical Information section, "you" and "your" refers to the person for whom insurance is requested.

Employee Name: _____

	Employee	Spouse/ Domestic Partner
1. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. chest pain or heart trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. high blood pressure, stroke or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. cancer or tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. anemia, leukemia or other blood disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you now receiving or applying for any disability benefits including workers' compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above questions, you must also complete and attach a Statement of Health form.

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(Continued on Following Page)

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of Enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependents 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.

For the Accelerated Benefits Option

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. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect 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.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %

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

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %

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

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature

Print Name

Date Signed (Mo./Day/Yr.)

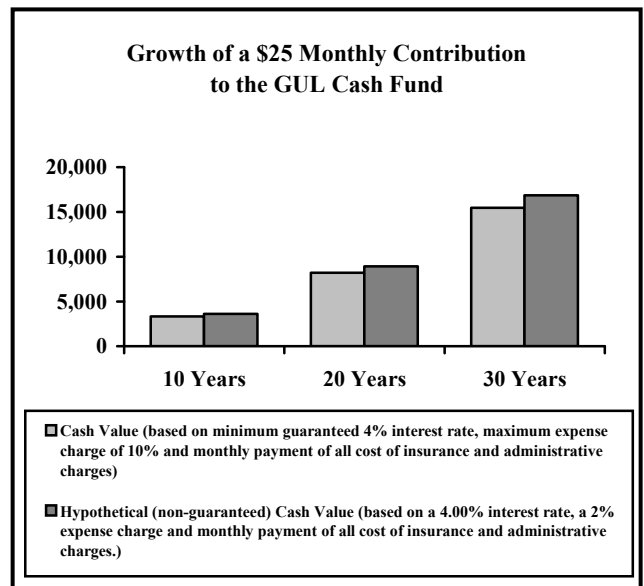
2011 Clackamas County Group Universal Life – Cash Value Quotation

See how fast your money can grow.

Group Universal Life (GUL) provides a Cash Fund feature to help maximize your coverage by providing more options and greater flexibility. With this feature, your contribution earns a guaranteed minimum* rate of interest on a tax-deferred basis.

As your cash fund grows, you may withdraw some or all of your cash – for any reason. Generally, there is no penalty for withdrawals and no tax due until total withdrawals exceed premium paid.¹ Or, you may save it for use in retirement or to increase your death benefit.

The chart to the right shows how a \$25 monthly contribution to the Cash Fund (in excess of all monthly cost of insurance and administrative charges) can add to your coverage and grow over time. You can contribute whatever amount is right for you.



10 Years

After 10 years, a \$25 monthly contribution can quickly accumulate in your Cash Fund, growing to \$3,606.** This will increase a \$50,000 death benefit to \$53,606 or could help you meet some of your goals like purchasing a new car.

20 Years

Left to grow, the same contribution after 20 years of tax-deferred growth in your Cash Fund can accumulate to \$8,943.** It will increase a \$50,000 death benefit to \$58,943 or could be used to help pay for some of your future goals like your child's education or wedding.

30 Years

Finally, your same planned monthly contributions over a longer period of time, say 30 years, can accumulate in your Cash Fund to \$16,844,** bringing a \$50,000 death benefit to \$66,844. This added financial benefit can also be used to help meet some of the income or insurance protection needs that most retirees face.²

The chart above shows two very different, yet possible, Cash Fund scenarios. One value shown — The Minimum Cash Value (the bars on the left) represents the minimum you would be guaranteed under the conditions specified. It assumes the maximum possible expenses under your GUL plan (10% of all incoming contributions), the minimum possible interest rate that can be credited to your Cash Fund 4% and monthly payment of all cost of insurance and administrative charges. For the current year, your GUL plan currently has 2% expense charge, and contributions to your Cash Fund are being credited with a 4.00% interest rate until 12/31/11. The Hypothetical Cash Value (the bars on the right) shows an accumulation scenario more closely aligned with your current GUL program because it assumes an interest rate that is less than or equal to the actual interest rate being credited to your Cash Fund and current expense charge of 2%.

To contribute to the GUL Cash Fund and make monthly contributions, be sure to complete the appropriate section on your Enrollment Form.

Circular 230 Disclaimer

The information contained in this presentation is not intended to (and cannot) be used by anyone to avoid IRS penalties. This presentation supports the promotion and marketing of MetLife GUL. You should seek advice based on your particular circumstances from an independent tax advisor.

Like most group life insurance policies, MetLife's policies contain certain condition, exclusions, limitations and terms for keeping them in force. Product features and availability may vary by state. For more information, refer to your enrollment materials or call MetLife at 1 800 GET-MET 8 (1-800-438-6388).

*Product guarantees are backed by the financial strength and claims paying ability of Metropolitan Life Insurance Company.

**This amount is based on the current non-guaranteed interest rate and is not guaranteed by MetLife.

¹ If the funding of your 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 59 ½ will also generally apply. We will notify you if a contribution would cause your certificate to become a MEC. Withdrawals will reduce your cash value and death benefit.

² In some plan designs, if the employer replaces MetLife GUL with group life insurance from another insurer or otherwise terminates the MetLife GUL group contract, employees' MetLife GUL coverage may also be terminated, even after separation from employment or in retirement.

Frequently Asked Questions (FAQ)

Q. Is there an advantage to buying group life insurance?

A. Yes! By applying during your enrollment or eligibility period, you can obtain coverage, subject to plan limitations, without answering detailed medical questions or undergoing a physical. Your cost of insurance is provided at competitive group rates. Paying for coverage is easier, and you won't have to worry about missing payments, since it's done through automatic payroll deductions.

Q. Who is eligible for coverage?

A. Employees and New Hires who enroll within their enrollment or eligibility period. Dependents are eligible, subject to plan design – please review your Plan Summary for complete details.

Q. What happens if I apply after the initial enrollment or eligibility period?

A. You can still apply for coverage, but you may have to complete a Statement of Health form, and perhaps have a physical exam, regardless of the coverage amount you select. MetLife will review your information and approve your request for coverage based upon your answers to the medical questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to complete your application. You should consider obtaining insurance when you know you are in good health, and not risk having a hard time qualifying for coverage if your health changes.

Q. When will my coverage request go into effect?

A. Coverage requests will become effective the first of the month following the receipt and approval of your enrollment by MetLife, as long as you are Actively at Work on that date. Coverage requests that require additional medical information and are not approved by this date will not be effective until the first of the month following approval from MetLife as long as you are Actively at Work on that date. See your Plan Summary or certificate for more information.

Q. Can I access my Cash Fund before I retire?

A. Yes. You may access your money through loans and withdrawals, provided there is adequate cash value in your fund. You can take only one loan at a time, the minimum being \$250, and there is no time limit on repayment. 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.*

Q. How do I know how much life insurance I need?

A. To help you determine how much life insurance coverage you may need, complete the Life Insurance Planner enclosed in your enrollment package. Or if you prefer, you can conveniently and quickly use the online calculator located at www.metlifeeasier.net/na.

Q. How do I apply?

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

Be sure to enroll before your enrollment or eligibility deadline.

*Loans & Withdrawals reduce the cash value and death benefit. In general, if you adhere to certain premium limits so that your policy is not considered a MEC, withdrawals will be subject to tax after policy basis has been reduced to zero. Policy basis is total premium paid (i.e., the cost of insurance and cash fund contribution) reduced by previous nontaxable withdrawals. If your policy is considered a MEC because you have exceeded certain premium limits, withdrawals and loans are taxable to the extent of policy gain (i.e., generally the excess of cash value over remaining basis) and a 10% penalty may apply if you are under age 59 ½.

Like most group insurance policies, MetLife group life insurance policies contain certain exclusions, limitations, reductions of benefits and terms for coverage. Please call MetLife at 1-800-GETMET-8 (1-800-438-6388) for more information.

MetLife Planning Tools

Your goal should be to develop a life insurance plan (through one or more policies) that in the event of your death, provides your family with a financial safety net while making up the loss of your income.

One basic approach to determining your family's life insurance needs is to consider completing the Life Insurance Calculator below. This can help you to determine how much insurance is right for you.

A

BASIC MONTHLY EXPENSES

These are the everyday expenses that your family has to meet. Decide how many years you would want your insurance to cover these expenses. Then, multiply the Annual Expenses by that number of years.

Monthly Expenses Consider expenses such as your mortgage/rent, household expenses, insurance cost and child care expenses)	\$	
Basic Annual Expenses (Monthly Expenses x 12)	\$	
Number of Years You Want These Expenses Covered (It could be 5, 10 or more years)		
Total Basic Expenses (Annual Expenses x Number of Years)	\$	1a

ADDITIONAL EXPENSES TO PLAN FOR

These are additional costs you and your family may have been planning for, so you may want to consider these as well.

Future Expenses (Consider expenses such College Tuition, Child(ren)' s Wedding(s), Personal Funeral Expenses, Elder Care for Parents)	\$	2a
--	----	----

OUTSTANDING DEBT

These are committed costs you may wish to pay off in full to protect your family from this burden.

Outstanding Debt (Consider Remaining Mortgage, Credit Card Bills, School or Auto loans)	\$	3a
--	----	----

TOTAL EXPENSES (1a + 2a + 3a)	\$	A
--------------------------------------	----	----------

B

AVAILABLE ASSETS

Assets (Consider Savings [cash, securities, etc.], Employer Savings Plan, Equity in Your home, current Employer-Paid and/or Other Life Insurance)	\$	B
--	----	----------

This is the amount of life insurance coverage you may need to provide adequate insurance protection for your family.

C

TOTAL COVERAGE NEEDED (A – B = C)	\$	C
--	----	----------

Additional Information About Group Universal Life Insurance

Minimum/Maximum Amounts of Insurance Coverage: Coverage minimums and maximums vary by case. Call the MetLife Benefits Line if you (“employee”) are unsure of your company’s plan specifics.

Incontestability Provision: There is a two-year contestability period during which any misstatements made by you can be used by MetLife to deny a claim.

Suicide Clause: The death benefit (or any increased portion of the death benefit) will not be paid if death by suicide occurs within two years of the effective date of the certificate (or for increased benefits, within two years of such increase). This clause can vary by state.

Reduction of Death Benefit: Upon your reaching age 70, or under other circumstances specified in your GUL certificate, your death benefit may reduce to five times the amount in your Cash Fund, not to exceed your current coverage amount. Minimum coverage is \$20,000.

Waiting Periods: You must be actively at work on the effective date of your coverage for coverage to be effective. If you are not actively at work on such date, coverage will become effective on the first of the month following the date you return to work with your company.

Changes in Your Cost of Insurance Rates/Premium: Premiums vary depending upon the amount of coverage and benefits selected. Additionally, your cost of insurance rates are based on your age and will increase as you get older. Rates are guaranteed until the policy renewal date. At the renewal date, rates will be recalculated and are subject to change. MetLife reserves the right to alter the rates and/or the rate guarantee period should overall group participation change significantly. Rates will also change if you leave your employer and choose to continue your coverage.

Termination of Coverage: If you fail to make a planned payment and the amount in your cash accumulation fund is insufficient to cover your cost of insurance, there will be a grace period of 60 days to pay the amount of the monthly deduction. If MetLife does not receive a sufficient amount by the end of the grace period, your coverage will then end. Either your employer or MetLife may terminate this program with sufficient notice to each other. If this program ends and your employer sponsors an alternate group life insurance plan (a “successor plan”), your MetLife GUL coverage will end if you are retired or paying via payroll deductions. Your MetLife GUL coverage will continue if you have exercised a portability option upon separation from employment and are being direct billed. If this program ends and there is no successor plan, you may continue your coverage as long as you arrange to make payments directly to MetLife.

Spouse/Domestic Partner* Coverage: If this benefit is offered to you, it is provided as a separate certificate and is **owned by the employee**. In the event of termination of marriage or your death, your spouse/domestic partner may request to remain insured under this program. In this event, your spouse/domestic partner would become the owner of the GUL certificate. Coverage is subject to state availability and regulations.

Dependent Child(ren)* Coverage: If this benefit is offered to you, child term coverage covers all of your children from age 14 days to 19 years with an extension to age 23 (or 25, depending on the program) if they are full-time college students. Coverage generally ends at the earlier of your retirement date, the date you die, when your spouse/domestic partner reaches age 70 (or 95, depending on the program), when the child reaches the limiting age or upon termination of the certificate to which it is attached. Conversion to an individual policy may be offered when child coverage terminates for any of the above reasons. Coverage is subject to state availability and regulations.

* In order for coverage to be effective, you must be actively at work with your employer, and your spouse/domestic partner/or child(ren) must not be confined to a hospital on the enrollment date, or at home for any medical reason or be receiving or entitled to receive disability income for any medical reason at the effective date of coverage. Additionally, you must enroll for additional coverage and make the required premium payment for additional coverage to be effective.

The above facts are intended to provide a brief description of certain certificate provisions which may be part of the GUL coverage. They do not constitute a contract. In all cases, the insurance certificate will govern. Coverage is provided under a master group insurance policy (Policy #G2130-S /GPN99). (MET)



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.

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, or group insurance or annuity contract. In this notice, “you” refers to these individuals.

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.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

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 Group, Inc. (“MIB”). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

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

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. 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

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act (“ HIPAA”) may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. 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 anything we learned as part of 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.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company
General American Life Insurance Company
SafeGuard Life Insurance Company**

**MetLife Insurance Company of Connecticut
SafeGuard Health Plans Inc.**



Your group life benefits are an important part of your personal benefits plan. At MetLife we understand how important it is for you to create your own safety net to protect you and your family. When you choose MetLife, you partner with a company that is committed to doing its best to help you meet your benefits needs. And because MetLife has been offering life insurance coverage for more than 140 years, we have the experience to understand what matters most to you. That's why we provide you access to knowledgeable service teams with the expertise necessary to assist you when you need them the most, and the tools and resources you need to make better decisions.

For more information on MetLife group life insurance coverage, contact your benefits administrator or MetLife.



Benefits for the **if in life**SM

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MetLife

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



Metropolitan Life Insurance Company Statement of Health Form Instructions

Based on your enrollment, a Statement of Health is required to complete your request for group insurance coverage. Below are instructions for Completing the Statement of Health Form

A separate Statement of Health form is required for each Proposed Insured / Applicant requesting insurance.

PLEASE USE THE CHECKBOXES TO ENSURE PROPER COMPLETION OF THE FORM.

Information to be Completed by Voluntary Benefits

- Enter SOH Reporting Location (if applicable)
- Select type of Insurance
 - If Life Insurance, **enter the additional amount of insurance**
- Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

Information to be Completed by Proposed Insured / Applicant

The Proposed Insured / Applicant must complete all information located in the boxes at the top:

- Enter Employee Name and Social Security Number**
- Enter Relationship of Proposed Insured / Applicant to Employee
- Enter Proposed Insured / Applicant's
 - Name
 - Sex
 - Date of Birth
 - Mailing Address
 - Business Telephone Number
- Home Telephone Number
- Email Address
- State of Birth
- Country of Birth

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- Complete Question 1.
- Check "Yes" or "No" for Questions 2–6 (**all parts**).
- Complete Question 7.
- Complete the details section if ANY of the questions 2 through 6 were answered "Yes."

Signatures

- The Employee must always sign and date the **Statement of Health** form.
- The Proposed Insured / Applicant (if over the age of 18) must sign and date the **Statement of Health and Authorization** forms. If the Proposed Insured / Applicant is under the age of 18, his/her personal representative must sign and date the Authorization.

Upon completion, detach the Consumer Privacy Notice and retain for your records. Make a copy of the completed form for your records and return the completed 3-page form to Voluntary Benefits in the enclosed envelope.

Note: Additional medical information may be required after initial review of completed forms. This information may be in the form of a physical examination, paramedical exam, or Attending Physician Report, in which correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned for completion. For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email ei@metlife.com.

STATEMENT OF HEALTH FORM

To be Completed by Voluntary Benefits

-PLEASE PRINT CLEARLY-

Employer Name Clackamas County	Customer Number 74414	Reporting Location Number	
Employer's Street Address 2051 Kaen Road	City Oregon City	State OR	Zip Code 97045
Insurance Requested (To be completed for each Proposed Insured / Applicant) <input type="checkbox"/> Group Universal Life <input type="checkbox"/> Dependent Life Additional Amount of Life Insurance Subject to Medical Underwriting \$ _____ Enrollment Year: _____			

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Employee Name (Must Complete)			First	MI	Last	Employee Social Security Number (Must Complete)			
Insurance is for: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child		Proposed Insured Name			First	MI	Last	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Mo Day Yr)
Mailing Address					City			State	Zip Code
Business Phone Number () ()	Home Phone Number () ()	E-mail Address			State of Birth		Country of Birth		

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OR

Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

- Height ____ feet ____ inches Weight ____ lbs
- Are you now:

	Yes	No
a. pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b. taking prescribed medications or on a prescribed diet? If "yes," list: _____	<input type="checkbox"/>	<input type="checkbox"/>
c. receiving or applying for any disability benefits including workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
- In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Yes No
- In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) _____ Yes No
- Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No		Yes	No
a. chest pain or heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	h. colitis, Crohn's or any intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. high blood pressure, stroke or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	i. Epilepsy, paralysis or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer or tumors?	<input type="checkbox"/>	<input type="checkbox"/>	j. mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. anemia, leukemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes? insulin treated?	<input type="checkbox"/>	<input type="checkbox"/>	l. arthritis, carpal tunnel, or any muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
f. asthma, tuberculosis, pneumonia, or other lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	m. kidney or urinary tract disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. ulcers, stomach or liver disorder?	<input type="checkbox"/>	<input type="checkbox"/>	n. thyroid or other gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			o. back, neck or spinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
- Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? Yes No
- Personal Physician: _____ Date and reason for last visit: _____
Address: _____ Phone Number: _____

Give full details for "Yes" answers on the next page.

GEF02-1 MQ

SOH-RK

OR
Clackamas County (04/08)

Give full details for “Yes” answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

GEF02-1 MQ

OR

Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.



(Employee must always sign)	
Signed _____	Date _____
(Proposed Insured if other than Employee and at least 18 years of age)	
Signed _____	Date _____

GEF02-1a DEC

SOH-RK

OR
Clackamas County (04/08)

**Make A Copy For Your Records and
Return the Completed Form to Voluntary Benefits in the Enclosed Envelope
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com**

Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, the proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.

Sign
Here

Signature of Proposed Insured or
Signature & Relationship of Personal Representative*

Print Name of Proposed Insured

Date Signed (Mo./Day/Yr.)

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. 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.