

ENROLLMENT FORM FOR NORTH BAY BUILDERS EXCHANGES

SECTION TO BE COMPLETED BY EMPLOYER

OPTIONAL COVERAGES ONLY

Name of Employer (Please Print) North Coast Builders Exchange Company Name:		Group Report No. 113506	Sub Division 0001	Branch
Employer's Street Address		City	State	Zip Code
Date of Hire (Mo./Day/Yr.)	Employee Base Annual Salary (BAS) \$	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:	<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Salaried	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
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.) _____ <input type="checkbox"/> Address Change <input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Other _____				

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 which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

Optional Life (You may elect coverage in \$10,000 increments up to the lesser of 5x Base Annual Salary or a maximum of \$300,000.)
Coverage Requested: \$ _____

Dependent Spouse / Child Coverage

Dependent Spouse Life* (You may elect coverage in \$10,000 increments up to the lesser of 50% of Employee Life Amount or a maximum of \$100,000.) Coverage Requested: \$ _____

Dependent Child Life* (You may elect coverage in \$2,500 increments up to the lesser of 50% of Employee Life Amount or a maximum of \$10,000)
Coverage Requested: \$ _____

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

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse)			
Name (Last, First, MI)	Date of Birth	Sex (M/F)	
Spouse: _____	_____	_____	
Child(ren): _____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

If dependent children are full-time students in college, vocational or trade school, please complete the following:

Child(ren)	Name of School
_____	_____
_____	_____
_____	_____
_____	_____

Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 2 years from the date of this enrollment form?

Employee **Spouse**
 Yes No Yes No

Medical Information

Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the person for whom insurance is requested.

1. Employee Name: _____
2. Employee: Height ____ feet ____ inches Weight ____ lbs.
Spouse: Height ____ feet ____ inches Weight ____ lbs.
- | | Employee | Spouse | Child(ren) |
|--|--|--|--|
| 3. Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?
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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. 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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you ever been diagnosed, treated, tested 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 | <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 | <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 | <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 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <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 you answered "Yes" to any of the above questions, you must also complete and attach a Statement of Health form.

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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. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date. If Hospitalized during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of good health satisfactory to MetLife.

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.

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 that 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.

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Optional Coverages Only

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of **METROPOLITAN LIFE INSURANCE COMPANY**.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- 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 your finances, employment, hobbies, mode of living, work history, and driving record.

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 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., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. Please identify the specific product or service you are writing about.