How to Apply for Long Term Disability Conversion Insurance

Please follow these steps to apply for Conversion:

1. Complete the LTD Conversion Application provided in this package. Please answer each question in full, sign, and date the application form. You do **not** have to supply medical evidence of insurability to obtain the converted coverage.

2. The Employer must complete the **Group Employer Questionnaire** provided in this package. If your employer provides you with a **Health and Insurance Plans Conversion/Portability Notice,** that can be used in lieu of the **Group Employer Questionnaire**.

3. For fastest results, email or fax your:
   - Completed Application for Long Term Disability Conversion Insurance; and
   - Group Employer Questionnaire or Health and Insurance Plans Conversion/Portability Notice to:
     - **Metropolitan Life Insurance Company**
       EMAIL: IDILTDConversions@metlife.com
       Fax : (866) 204-1962
     - You may also mail the Application and Questionnaire to:
       Metropolitan Life Insurance Company
       P.O. Box 306Warwick, RI 02887-0306

4. The Application and Questionnaire must be **returned to our office within 31 days** of the date on which your employment ends or you cease to be in an eligible class.

The Conversion Privilege is available to you if:

- The Group Policy is in effect;
- We have not received notice from the Policyholder of its intent to end the Group Policy;
- You reside in a jurisdiction that permits portability;
- You have been insured for at least 12 months prior to the date that your employment ends;
- Your employment did not end as a result of your retirement;
- You are not disabled; and
- You have not become insured under any other disability insurance plan within 31 days after the date your Portability Eligible Disability Income Insurance ends under the Group Policy.

The Conversion Privilege is *not* available to you if:
The Group Policy is amended to exclude the class of employee to which you belong.

How you will know if your application is approved or denied:
Once a decision has been reached, Metropolitan Life Insurance Company will promptly notify you using the contact information provided in the LTD Conversion Application. If approved, Metropolitan Life Insurance Company will notify you of the following:

- The Effective Date of coverage;
- The Benefit Amount;
- The Elimination Period; and
- The amount of the Quarterly Premium and any pro-rated amount due.

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

APPLICATION FOR LONG TERM DISABILITY CONVERSION INSURANCE

The applicant named below is applying for a conversion of Long Term Disability Insurance to provide insurance for the persons specified below. Note: All questions must be fully completed. Failure to fully complete the form may result in the applicant being denied coverage.

APPLICANT DATA

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	
Former Employer's Name	Occupation	
Your employment in the eligible class terminated on (MM/DD/YYYY)	Last monthly salary	

Did you retire? ☐ Yes ☐ No

Are you covered under another group plan other than the employer listed above? ☐ Yes ☐ No

Are you currently disabled under your group disability plan? ☐ Yes ☐ No

Preferred method for us to contact you?

☐ Email
☐ Fax
☐ Phone
☐ Mail

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)*

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.

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

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

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

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

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

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

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

New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE

Sign Here

Signature of Applicant	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)*

In order to complete review of the application, the following must be submitted:

- □ This Application, completed and signed; and
- □ Employer Questionnaire Form or Health and Insurance Plans Conversion / Portability Notice

Your insurance will not become effective until you receive approval and an effective date for your Long Term Disability Conversion Insurance from Metropolitan Life Insurance Company.

How to Submit this form:
EMAIL: IDILTDConversions@metlife.com
FAX: (866) 204-1962
MAIL: P.O. Box 306
Warwick, RI 02887-0306

MetLife

GROUP EMPLOYER QUESTIONNAIRE FOR LONG TERM DISABILITY CONVERSION INSURANCE

The applicant named below is applying for a conversion of Long Term Disability Insurance to provide insurance for the person specified below. **Note:** All fields must be fully completed and signed by the employer or Third Party Administrator (TPA). Failure to fully complete the form may result in the applicant being denied coverage.

APPLICANT DATA

1. Full legal name of Applicant:_____(the "Policyholder")
2. Date of Hire: _____/ _____/ _____
3. Effective Date of Insurance under group LTD Policy: _____/ _____/ _____
4. Group LTD Policy Number: _____
5. Last Date of Coverage: _____/ _____/ _____
6. Is the Employee now disabled from a sickness or injury? Yes No
7. Did the Employee leave employment as a result of Retirement? Yes No
8. Is there a disability claim for this employee pending under your LTD Policy? Yes No
9. Occupation Class at time of termination from employment: _____
10. Employee's Occupation at time of termination from employment: _____
11. Last monthly salary: $_____

The statements set forth above are true to the best of my knowledge and belief.

_____
SIGNATURE OF PREPARER

Signature of Preparer Date: _____

Email Address of Preparer: _____

Contact Phone of Preparer: _____

How to Submit this form:

EMAIL: IDILTDConversions@metlife.com
FAX: (866) 204-1962
MAIL: P.O. Box 306
Warwick, RI 02887-0306

MetLife

CONVERSION SCHEDULE OF BENEFITS

ELIMINATION PERIOD: 180 days

MONTHLY BENEFIT: The Monthly Benefit is the lesser of:

1. The Maximum Monthly Benefit shown below minus Other Income Benefits; and
2. 60% of Basic Monthly Earnings minus Other Income Benefits.

Other Income Benefits are described in REDUCTION OF BENEFITS on page 10.

MAXIMUM MONTHLY BENEFIT: $3,000.00

MINIMUM MONTHLY BENEFIT: $50.00

MAXIMUM BENEFIT DURATION:

The Maximum Benefit Duration shall be the greater of:

- The Benefit Duration limit as shown in the table below; and
- The Insured's normal retirement age as defined by the Social Security Amendments of 1983.

Total Disability Begins	Benefit Duration
Less than age 60	To Age 65
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69+	12 months

MetLife

RATES

Policy will provide 60% of earnings prior to termination of employment up to a maximum monthly benefit of $3,000. Disability benefits will be reduced by those other income benefits, which are standard in our group policies. Both the benefit percentages and the maximum monthly benefit will be reduced to that of the former group policy if they are lower.

No medical evidence of insurability for issue will be required.

Quarterly premium rates per $100 of monthly benefit are as follows:

Premium

Age	2 year Own Occupation	Any and Every Occupation
<25	3.84	3.69
25-29	4.08	3.92
30-34	5.53	5.31
35-39	9.08	8.72
40-44	14.14	13.57
45-49	23.20	22.27
50-54	35.97	34.53
55-59	47.42	45.52
60+	49.18	47.21

Exclusions apply: The policy does not cover any Total Disability which results from or is caused or contributed to by: war, insurrection, or rebellion; active participation in a riot; intentionally self-inflicted injuries or attempted suicide; the commission of a felony; a pre-existing condition, as defined under the Former Plan, for which no benefit would have been payable had coverage continued under the Former Plan.

Policies may be issued under Form G.24104, G.24105, or G.24106