

INSTRUCTIONS

FOR THE STATEMENT OF HEALTH FORM AND THE AUTHORIZATION FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE MEMBER/EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Member/Employee's Name and the Member/Employee's Social Security # must appear on the form.
2. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
3. Complete the Statement of Health form and sign where indicated by an arrow.
4. Sign the Authorization form where indicated by an arrow.
5. After completion, make a copy of both completed forms for your records and FAX or MAIL the original forms to the recordkeeper.

INSTRUCTIONS TO THE PLAN ADMINISTRATOR

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form.
2. After completion, make a copy of both completed forms for your records and FAX or MAIL the original forms to the address at the right.

For **QUESTIONS**, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at LMSOH@metlife.com.

Metropolitan Life Insurance Company,
 Medical Underwriting
 P.O. Box 14593
 Lexington, KY 40512-4593
 FAX: 1-888-505-7446
 To submit by Email:
METLIFESOH@metlife.com



Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer.

These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.



MetLife

Metropolitan Life Insurance Company, New York, NY 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Plan Administrator)

Name of Association California Association of REALTORS®		Association # TS05726225	
Street Address 19310 Sonoma Highway, Suite A	City Sonoma	State CA	Zip Code 95476

INSURANCE INFORMATION (To be Completed by the Member/Employee)

Term Life Insurance

- Supplemental/Optional Life: Amount subject to medical underwriting \$25,000 \$50,000

MEMBER/EMPLOYEE INFORMATION (To be Completed by the Member/Employee)

Name of Member/Employee (First, Middle, Last)			Social Security #		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address		City		State		Zip Code
Date of Birth (MM/DD/YYYY)	Business Phone #	Home Phone #	Email Address			
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Rehire		Date of Membership/Hire (MM/DD/YYYY)		State of Birth		Country of Birth

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)

After completion, make a copy for your records and return the original to:

RealCare Insurance Marketing, 430 W. Napa, Suite F, Sonoma, CA 95476 or fax to 707-935-7142. Questions, 800-939-8088

California Association of REALTORS®

SOH-ST400S-CA (09/20)

HEALTH INFORMATION

SECTION 1
 Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 12t, for "yes" answers, please provide full details in Section 2.

Your name _____ Member/Employee's Name _____
 Member/Employee's Social Security/Identification # _____

	Yes	No
1. Your height ___ feet ___ inches Your weight ___ pounds	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____ If "yes", provide Physician's name _____ Telephone: (____) _____ - _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you now, or have you in the past 2 years, used tobacco in any form?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had any application for life, accidental death and dismemberment or disability insurance <input type="checkbox"/> declined <input type="checkbox"/> postponed <input type="checkbox"/> withdrawn <input type="checkbox"/> rated <input type="checkbox"/> modified or <input type="checkbox"/> issued other than as applied for? Indicate reason _____	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days? Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	<input type="checkbox"/>	<input type="checkbox"/>
10. For residents of all states except CT, please answer the following question: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past 5 years, have you been diagnosed, treated or given medical advice by a physician or other health care provider for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
b. stroke or circulatory disorder (such as peripheral artery disease)? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
d. anemia, leukemia or other blood disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes? Your age at diagnosis? _____ <input type="checkbox"/> Check if insulin treated	<input type="checkbox"/>	<input type="checkbox"/>
f. asthma, COPD, emphysema or other lung disease? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
g. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
h. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
i. memory loss? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
j. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
k. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
l. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
m. lupus, scleroderma, auto immune disease or connective tissue disorder?	<input type="checkbox"/>	<input type="checkbox"/>
n. arthritis? <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____	<input type="checkbox"/>	<input type="checkbox"/>
o. back, neck, knee, spinal, joint or other musculoskeletal disorder (such as herniated disc; back pain; cervical spondylosis; meniscal, cartilage or ligament tears or injuries; hip fracture; or tendonitis)? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
p. carpal tunnel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
q. kidney, urinary tract or prostate disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
r. thyroid or other gland disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
s. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>
t. sleep apnea? Indicate type _____	<input type="checkbox"/>	<input type="checkbox"/>

After completing the Personal Physician and Prescription Information on the next page, please provide full details in Section 2 for "yes" answers to questions 5 through 12t.

GEF09-1a
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;
GEF09-1
HEA applies to residents of Connecticut, North Dakota and Utah)

Please complete all sections of this form. Incomplete forms will be returned to you.

Personal Physician Information	
Personal Physician's Name: _____	
Address (Street, City, State, Zip Code): _____	Telephone: (____) _____ - _____
Date of last visit (MM/DD/YYYY): ____ / ____ / ____	Reason for visit: _____

Prescription Information	
Are you currently taking any prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the medications.	
Medication: _____	Condition/Diagnosis: _____
Prescribing Physician's Name: _____	Telephone: (____) _____ - _____
Address (Street, City, State, Zip Code): _____	
Medication: _____	Condition/Diagnosis: _____
Prescribing Physician's Name: _____	Telephone: (____) _____ - _____
Address (Street, City, State, Zip Code): _____	
<input type="checkbox"/> Check here if you are attaching another sheet for any additional medications.	

SECTION 2
Please provide full details below for each "Yes" answer to questions 5 through 12t in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. <input type="checkbox"/> Check here if you are attaching another sheet.

Your name _____	Member/Employee's Name _____
Your Date of Birth ____ / ____ / ____	

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: (____) _____ - _____		

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: (____) _____ - _____		

GEF09-1a
 (The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;
GEF09-1
HEA applies to residents of Connecticut, North Dakota and Utah)

Please complete all sections of this form. Incomplete forms will be returned to you.

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.		
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment		
Treating Health Professional				
Physician's Name: _____				
Date of last visit: _____ Reason for visit: _____				
Address				
Street		City	State	Zip Code
Telephone: () -				

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF09-1

HEA applies to residents of Connecticut, North Dakota and Utah)

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

GEF09-1a

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;

GEF09-1


FW applies to residents of Connecticut, North Dakota and Utah)

Please complete all sections of this form. Incomplete forms will be returned to you.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.

 Sign Here

_____	_____	_____
Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1a

*(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)

Please complete all sections of this form. Incomplete forms will be returned to you.

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("member", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:


- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, 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;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

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

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse 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.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

	_____ Signature of Proposed Insured		_____ Date Signed (MM/DD/YYYY)
	_____ Print Name	_____ State of Birth	_____ Country of Birth