

INSTRUCTIONS

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

INSTRUCTIONS TO THE RECORDKEEPER (The Recordkeeper may be the Group Customer, a Third Party Administrator or MetLife.)

1. Fill in the Group Customer Information and Insurance Information on the Statement of Health form.
2. Give the forms to the Employee.

INSTRUCTIONS TO THE EMPLOYEE

1. Fill in your name and Social Security # on the Statement of Health form. The Employee's Name and the Employee's Social Security # must appear on the form.
2. Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee or the Employee's Spouse.) A separate Statement of Health form must be completed by each Proposed Insured. Based on the enrollment form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. If the Insurance Information Section is not completed, obtain the information before finalizing the form. Contact your Employer/Benefits Administrator if the Life Insurance amounts were not provided or to confirm the Life Insurance amounts.
2. Complete the Statement of Health form and sign where indicated by an arrow.
3. Sign the Authorization form where indicated by an arrow.
4. After completion, make a copy of both completed forms for your records and FAX, MAIL or EMAIL the original forms to the address at the right. Emailed forms must be printed and signed before they are scanned and submitted.



Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

To Submit Completed Forms Email:
SOHSubmissions@metlife.com

For Questions Email:
eoim@metlifeservice.com

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoim@metlifeservice.com.

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

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

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



STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)			
Name of Group Customer/Employer/Association South Carolina Public Employee Benefit Authority		Group Customer # 200879	Reporting Location # H120000
Street Address 202 Arbor Lake Dr	City Columbia	State SC	Zip Code 29223
INSURANCE INFORMATION (To be Completed by the Recordkeeper)			Enrollment year
Term Life Insurance			
<input type="checkbox"/> Supplemental/Optional Life			
Current amount \$	Amount subject to medical underwriting \$	Total amount requested \$	
<input type="checkbox"/> Dependent Spouse ¹ Life			
Current amount \$	Amount subject to medical underwriting \$	Total amount requested \$	
EMPLOYEE INFORMATION (To be Completed by the Employee)			
Name of Employee (First, Middle, Last)		Social Security # of Employee	
YOUR INFORMATION (To be Completed by the Proposed Insured)			
Name (First, Middle, Last)		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address	City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address

¹ For Vermont and Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

GEF02-1 ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;
GEF02-1 ADM applies to residents of Connecticut, North Dakota and Utah)

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

HEALTH INFORMATION

SECTION 1

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested. Health Information is required for the Proposed Insured only. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

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

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Your height __ feet __ inches Your weight __ pounds | | |
| 2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____ | <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), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?
For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | | |
| a. cardiac or cardiovascular disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b. stroke or circulatory disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cancer, Hodgkin's disease, lymphoma or tumors? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. anemia, leukemia or other blood disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes? Your age at diagnosis? __ <input type="checkbox"/> Check if insulin treated | <input type="checkbox"/> | <input type="checkbox"/> |
| g. asthma, COPD, emphysema or other lung disease? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| j. memory loss? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| k. epilepsy, paralysis, seizures, dizziness or other neurological disorder?
Specify date of last seizure (month/year) __ Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| m. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| n. lupus, scleroderma, auto immune disease or connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. arthritis? <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| p. back, neck, knee, spinal, joint or other musculoskeletal disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| q. carpal tunnel syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. kidney, urinary tract or prostate disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| s. thyroid or other gland disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| t. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| u. 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 11u.

GEF09-1

HEA

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

GEF09-1

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

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



Metropolitan Life Insurance Company, New York, NY 10166

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? Yes 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): _____

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 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. Check here if you are attaching another sheet.

Your name _____ Employee's Name _____

Your Date of Birth ____ / ____ / ____

Question Number	Condition/Diagnosis	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Physician's Name: _____		
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: (____) ____ - _____		

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

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

South Carolina Public Employee Benefit Authority
SOH-XDP100M-NW (05/20)

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: () - _____				

GEF09-1

HEA

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

GEF09-1

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

FRAUD WARNINGS

Before signing this 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.

GEF09-1

FW

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

GEF09-1

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

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

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

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



_____	_____	_____
Signature of Proposed Insured	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)*

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) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB 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

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company (“MetLife”) or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company. MIB, upon request, will supply such company with the information in its file.

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

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



Delaware American Life Insurance Company
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
MetLife Health Plans, Inc.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

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

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file.

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

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

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

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

ACTIVE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY

A

See Instructions - if completing
by hand use black ink

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION	Select One	Type of Change	BA Use Only	
	<input type="checkbox"/> New Hire/Election	<input type="checkbox"/> Enrollment	Effective Date: _____	<input type="checkbox"/> Permanent P/T EE (20 hrs.)
	<input type="checkbox"/> Transfer	Other (specify) <u>Open Enrollment</u>	Group ID #: <u>H12000</u>	Pay periods per year: _____
	<input checked="" type="checkbox"/> Change	Date of Change Event _____	Group Name: <u>Clemson University</u>	

Eligible due to the Affordable Care Act: Full-time nonpermanent Variable-hour

1. Social Security number or BIN	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth (MM/DD/YYYY)
7. Sex <input type="checkbox"/> M <input type="checkbox"/> F	8. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated	9. Home Phone #	10. Work Phone #	11. Email Address	
12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code
				18. Annual Salary \$ _____	19. Hire Date (MM/DD/YYYY)

COVERAGE	20. HEALTH PLAN (Refuse or select one plan and one level of coverage)		21. DENTAL (Refuse or select one plan and one level of coverage)	
	PLAN	COVERAGE LEVEL	PLAN	COVERAGE LEVEL
	<input type="checkbox"/> Refuse <input type="checkbox"/> Standard <input type="checkbox"/> Savings <input type="checkbox"/> TRICARE Supplement	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Refuse <input type="checkbox"/> Dental Plus <input type="checkbox"/> Basic Dental	<input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family
22. DEPENDENT LIFE Child(ren) (select one)	23. DEPENDENT LIFE Spouse (select one)	24. OPTIONAL LIFE (select one)	25. SUPPLEMENTAL LTD (select one)	26. VISION CARE (select one)
<input type="checkbox"/> Refuse <input type="checkbox"/> \$15,000	<input type="checkbox"/> Refuse <input type="checkbox"/> Total Coverage Amount \$ _____	<input type="checkbox"/> Refuse <input type="checkbox"/> Total Coverage Amount \$ _____	<input type="checkbox"/> Refuse <input type="checkbox"/> Plan One - 90-day waiting period <input type="checkbox"/> Plan Two - 180-day waiting period	<input type="checkbox"/> Refuse <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family

27. MONEYPLUS ELECTIONS MoneyPlus Pretax Premiums Refuse Yes

If you enroll in a health savings account (Section C), you cannot enroll in a medical spending account (Section A), but may enroll in a limited-use medical spending account (Section D). There is a monthly fee of \$2.32 for medical spending, dependent care, and limited-use medical spending accounts. There is a monthly fee of \$1.00 for health savings accounts.

MONEYPLUS ELECTIONS	A. MEDICAL SPENDING ACCOUNT		B. DEPENDENT CARE SPENDING ACCOUNT (for child/adult daycare)	
	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Refuse		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Refuse	
	Receive reimbursement for eligible medical expenses incurred by you, your family members, or both. The maximum allowable contribution is \$2,750 annually.		Tax filing status, please check one: <input type="checkbox"/> Married, filing separately (Maximum - \$2,500) _____ Daycare costs increase/decrease <input type="checkbox"/> Single, head of household (Maximum - \$5,000) _____ Dependent child turns 13 <input type="checkbox"/> Married, filing jointly (Maximum - \$5,000)	
	Plan year total amount: \$ _____		Plan year total amount: \$ _____	
C. HEALTH SAVINGS ACCOUNT		D. LIMITED-USE MEDICAL SPENDING ACCOUNT		
<input type="checkbox"/> New Account <input type="checkbox"/> Contribution Amount Change <input type="checkbox"/> Refuse		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Refuse		
Select which type of State Health Plan Savings Plan coverage you have: <input type="checkbox"/> Individual (Maximum - \$3,550) <input type="checkbox"/> Family (Maximum - \$7,100) <input type="checkbox"/> Over 55 Catch-up (additional \$1,000)		Receive reimbursement for eligible dental and vision expenses incurred by you, your family members, or both. The maximum allowable contribution is \$2,750 annually.		
Plan year total amount: \$ _____		Plan year total amount: \$ _____		

Qualified Change Events (Check and date all that apply) for A & B:

_____ Marriage	_____ Spouse/dependent passed away	_____ Spouse ends unpaid leave	_____ Other
_____ Newborn	_____ Employee begins unpaid leave	_____ Spouse begins unpaid leave	
_____ Adoption	_____ Employee ends unpaid leave	_____ Job change from part-time to full-time	
_____ Divorce	_____ Ineligible dependent child	_____ Job change from full-time to part-time	

EMPLOYEE INITIALS _____ **DATE** _____

Social Security number: _____ BIN: _____ Last Name: _____ First Name: _____

MEDICARE

28. List yourself and any other persons to be covered who are eligible for Medicare Part A and/or Part B.

Name	Medicare #	Eligible due to	Effective Date	
		<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease	Part A (MM/DD/YYYY)	Part B (MM/DD/YYYY)
		<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> Renal Disease		

In blocks 29 and 30, if there are additional beneficiaries or dependents, list on a separate sheet, signed and dated by employee.

BENEFICIARIES

29. Basic Life/Optional Life (select one or both)	SSN	Last Name	First Name	Relationship	Date of Birth (MM/DD/YYYY)	Primary or Contingent?
<input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Life						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Life						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Life						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<input type="checkbox"/> Basic Life <input type="checkbox"/> Optional Life						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

If beneficiary is an estate or trust, complete the following:
 Estate/Trust _____ Address _____ If trust, Date signed _____

30. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible or Dependent Life-Child coverage, your child must be eligible according to the requirements on the instructions page for this NOE.

DEPENDENTS

Add (A) or Delete (D)	Dependent SSN	Last Name	First Name	Sex	Relationship	Date of Birth (MM/DD/YYYY)	Indicate Special Status
							Does PEBA Insurance Benefits already cover your spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Incapacitated
							<input type="checkbox"/> Incapacitated
							<input type="checkbox"/> Incapacitated
							<input type="checkbox"/> Incapacitated

CERTIFICATION & AUTHORIZATION

31. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

32. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Phone _____ Date _____

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a *Certification Regarding Tobacco Use* form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, vision and Optional Life up to \$50,000 are deducted on a pretax basis unless refused. Pretax MoneyPlus changes must be made during enrollment or within 31 days of a qualifying change in status event.

Blocks 1-19: ENROLLEE INFORMATION: Must be completed for all transactions, including a refusal of coverage.

COVERAGE: Alterations (such as mark-throughs or white out) in this section are not allowed. To enroll, select the coverage and select the coverage level, if applicable. To refuse or cancel coverage, select Refuse.

Block 20: HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer.

If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation.

If health coverage is refused, benefits for Basic Life and Basic Long Term Disability are forfeited. To select a health plan, check only one block under Health Plan and check only one block under Coverage Level. For dependent(s) to be covered, they must be listed in **Block 30**, and the appropriate level of coverage must be selected.

Block 21: DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in **Block 30**, and the appropriate level of coverage must be selected.

Block 22: DEPENDENT LIFE - CHILD(REN): For child(ren) to be covered for Dependent Life Insurance, they must be listed in **Block 30**. To be eligible, they must be unmarried; must be supported by you; must not be employed on a full-time basis; and must not be in the military. In addition, for a child age 19-24 to be eligible the child must be certified by the PEBA as incapacitated at the time of enrollment or must be a full-time student at an accredited school, college or university. Children older than 24 must be certified by PEBA as incapacitated to be enrolled in Dependent Life-Child. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid.

Block 23: DEPENDENT LIFE - SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total amount of coverage for your spouse, not to exceed 50 percent of your current level of Optional Life, or \$100,000. Approved medical evidence of good health is required if coverage exceeds \$20,000. For your spouse to be covered, he must be listed in **Block 30**.

Block 24: OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer. To select coverage, check Total Coverage Amount and enter the total amount of coverage. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus Pretax Premium Feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

Block 25: SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer. Check only one block. If changing from Plan Two to Plan One, medical evidence of good health must be provided.

Block 26: VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 27: MONEYPLUS ELECTIONS: To enroll in a **Medical Spending Account**, complete **Section A**. To enroll in a **Dependent Care Spending Account**, complete **Section B**. Complete **Section C** to enroll in or to change a **Health Savings Account**. (Additional forms will be required to establish your HSA. Refer to your *Tax-Favored Accounts Guide* for more information.) If you would also like to enroll in a **limited-used Medical Spending Account** for eligible dental and vision expenses, complete **Section D**.

Block 28: MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

Block 29: BENEFICIARIES: List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

Block 30: DEPENDENTS: Legal documentation is required for all dependents. If you select a level of coverage that includes a spouse and/or dependent child (ren), they must be listed to be covered. A spouse can only be covered as a dependent if he is not an employee or retiree of an employer that participates in the state of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of an employer covered by PEBA insurance, check Yes. A child younger than 26 is eligible for health, dental and vision coverage. Misstatements on the NOE may result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

Block 31. CERTIFICATION AND AUTHORIZATION: Employees must initial and date the first page in the area provided. The second page of the form must be signed and dated by employee within 31 days of hire or the qualifying event. The benefits administrator must sign and date form and attach copies of all supporting documentation before submitting it to **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661**.