

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, the Employee's Spouse or the Employee's Child.) 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:
eoi@metlifeservice.com

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



Metropolitan Life Insurance Company, New York, NY 10166

STATEMENT OF HEALTH FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer/Association PEBB Benefits - State of Washington		Group Customer # 164995	Reporting Location #	
Street Address	City	State	Zip Code	

INSURANCE INFORMATION (To be Completed by the Recordkeeper) Enrollment year 2024

Term Life Insurance

- Basic Life: Indicate amount subject to medical underwriting _____
- Supplemental/Optional Life: Indicate amount subject to medical underwriting _____
- Dependent Spouse¹: Indicate amount subject to medical underwriting _____
- Dependent Child Life: Indicate amount subject to medical underwriting _____

EMPLOYEE INFORMATION (To be Completed by the Employee)

Name of Employee (First, Middle, Last)	Social Security # of Employee
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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"/> Child		
Street Address	City	State	Zip Code	
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

¹ 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-WAHCA
ADM**

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 11p, 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 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. 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. multiple sclerosis, ALS or muscular dystrophy? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| k. lupus, scleroderma, auto immune disease or connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |

- l. arthritis? osteoarthritis rheumatoid other/type _____
- m. kidney, urinary tract or prostate disorder? Indicate type _____
- n. thyroid or other gland disorder? Indicate type _____
- o. mental, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____
- p. sleep apnea? Indicate type _____

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 11p.

Personal Physician Information	
Personal Physician's Name: _____	Telephone: () - _____
Approximate last visit (MM/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: () - _____
Medication: _____	Condition/Diagnosis: _____
Prescribing Physician's Name: _____	Telephone: () - _____
<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 11p 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 _____	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: _____		Telephone: () - _____
Approximate last visit: _____ Reason for visit: _____		

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: _____		Telephone: () -
Approximate last visit: _____ Reason for visit: _____		

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: _____		Telephone: () -
Approximate last visit: _____ Reason for visit: _____		

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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.

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

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.

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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)

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured.** A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

	_____		
	Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)
	_____ Relationship of Personal Representative		

**GEF09-1-WAHCA
DEC**

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

