

Metropolitan Life Insurance Company

Statement of Health Form

Instructions for Completing Statement of Health Form

A separate Statement of Health form is required for each Proposed Insured requesting insurance.

Information to be Completed by Proposed Insured

The Proposed Insured must complete all information located in the boxes at the top:

- Select Type of Insurance. If Life Insurance, enter the additional amount of insurance
- Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only
- Complete Employee Name, Employee Social Security Number**
- Relationship of Proposed Insured to Employee, Proposed Insured Name, Sex, Date of Birth
- Address
- Business and Home Telephone Number, E-mail Address, State of Birth, Country of Birth

****NOTE: The Employee's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- Complete Question 1.
- Check "Yes" or "No" for Questions 2–6 (all parts).
- Complete Question 7.
- Complete the details section if any of the questions 2-6 were answered "Yes."

The employee must always sign and date his/her form.

Any dependent age 18 or older requesting insurance must sign and date his/her form.

Upon completion of the Proposed Insured Information, detach the Consumer Privacy Notice and retain for your records. Make a copy of the completed form for your records and return the completed 3-page form to:

**Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069**

For inquiries, contact 1-800-638-6420, prompt 1 (Statement of Health Unit).

STATEMENT OF HEALTH FORM

Employer Information

| | | | |
|---|-----------------------|----------------------------------|---|
| Employer Name Saint Alphonsus Regional Medical Center | TRINITY HEALTH | Customer Number 105068 | Reporting Location Number 908 |
| Employer's Street Address 1055 North Curtis Rd. | City Boise | State ID | Zip Code 83706 |

To be Completed by the Proposed Insured (A separate form must be completed for each Proposed Insured)

| | | | | |
|--------------------------------------|-------|----|------|--|
| Employee Name (Must Complete) | First | MI | Last | Employee Social Security Number (Must Complete) |
|--------------------------------------|-------|----|------|--|

Insurance Requested (To be completed for each Proposed Insured)

Employee Basic Life Employee Supplemental Life Dependent Spouse Life Dependent Child Life

Additional Amount of Life Insurance Subject to Medical Underwriting \$ _____ (Pended Volume from Confirmation Statement)

Enrollment Year: _____

| | | | | | | |
|--|--------------------------|----------------|----|-------|--|---------------------------|
| Insurance is for <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Child | Proposed Insured Name | First | MI | Last | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth (Mo Day Yr) |
| Street Address | City | | | State | Zip Code | |
| Business Phone Number () | Home Phone Number () | E-mail Address | | | State of Birth | Country of Birth |

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ADM

Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

- Height ____ feet ____ inches Weight ____ lbs
- Are you now:

| | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. taking prescribed medications or on a prescribed diet? If "yes," list: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| c. receiving or applying for any disability benefits including workers' compensation? | <input type="checkbox"/> | <input type="checkbox"/> |
- In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Yes No
- In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) _____ Yes No
- Have you ever been diagnosed, treated, tested or given medical advice by a physician or other health care provider for:

| | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| a. chest pain or heart trouble? | <input type="checkbox"/> | <input type="checkbox"/> | h. colitis, Crohn's or any intestinal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. high blood pressure, stroke or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> | i. Epilepsy, paralysis or dizziness? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. cancer or tumors? | <input type="checkbox"/> | <input type="checkbox"/> | j. mental or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. anemia, leukemia or other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> | k. Lyme disease, Epstein-Barr or chronic fatigue syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. diabetes? insulin treated? | <input type="checkbox"/> | <input type="checkbox"/> | l. arthritis, carpal tunnel, or any muscle weakness? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. asthma, tuberculosis, pneumonia, or other lung disease? | <input type="checkbox"/> | <input type="checkbox"/> | m. kidney or urinary tract disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. ulcers, stomach or liver disorder? | <input type="checkbox"/> | <input type="checkbox"/> | n. thyroid or other gland disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | o. back, neck or spinal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
- Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunity Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immune Deficiency Virus (HIV) infection? Yes No
- Personal Physician: _____ Date and reason for last visit: _____
Address: _____ Phone Number: _____

Give full details for "Yes" answers on the next page.

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SOH/NW

Trinity Health (09/03)

**EMPLOYEE – Make A Copy For Your Records & Return the Completed Form to:
MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit)**

Give full details for “Yes” answers. If more space is needed for full details, attach a separate sheet, sign and date it.

| Question Number | Dates of Treatment | Diagnosis/Condition | Duration | Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code |
|-----------------|--------------------|---------------------|----------|--|
| | | | | |
| | | | | |
| | | | | |

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas and Oregon: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

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

In any other case, read the following warning.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.



| | |
|--|------------|
| (Employee must always sign) | |
| Signed _____ | Date _____ |
| (Proposed Insured if other than Employee and at least 18 years of age) | |
| Signed _____ | Date _____ |

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DEC**

SOH/NW

Trinity Health (09/03)

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Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
 - 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 Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immune deficiency Virus (HIV) test results; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to the proposed insured obtaining insurance coverage. In all other cases, 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.
- 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.
- Each proposed insured has a right to receive a copy of this form.

A photocopy of this form is as valid as the original form.



Signature of Proposed Insured or

Print Name of Proposed Insured

Date (Mo./Day/Yr.)

Signature & Relationship of Personal Representative*

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. 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.

PRIVACY NOTICE

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

This Privacy Notice is given to you on behalf of each of these companies:

Metropolitan Life Insurance Company

Paragon Life Insurance Company

Please read this Privacy Notice carefully. It describes how we learn about you and how we treat that information. (If anyone else is proposed for insurance, what we say here also applies to information about them.)

Why We Need Information: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need it to administer your business with us, evaluate claims, process transactions and run our business. And we need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

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

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

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

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about your finances, employment, hobbies, mode of living, work history, and driving record.

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

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (617) 426-3660, or by contacting MIB at www.mib.com.

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

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

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

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

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

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

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise, we don't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, to you.

You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement in any future disclosure of Information.

You Can Get Other Material from Us: This is a general description of our information practices. We treat your information in accordance with applicable laws. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to us at MetLife, c/o MetLife Privacy Office, P.O. Box 2006 Aurora, Illinois 60507-2006.