TMA Insurance

DISABILITY & BUSINESS OVERHEAD EXPENSE INSURANCE APPLICATION
Metropolitan Life Insurance Company, New York, NY

FULL EVIDENCE OF INSURABILITY ENROLLMENT FORM

MetLife

Sponsoring Organization: Tennessee Medical Association | Customer Number: 165929

YOUR ENROLLMENT INFORMATION

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)
Email Address	Phone #	Occupation

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for benefits I select below.

Disability Income Insurance

Select your monthly benefit: Enter a multiple of $100 $_____ **Salary** $_____
The maximum monthly benefit amount is the lessor of $10,000 or 66.67% of your salary.

Indicate your Elimination Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

Select Maximum Benefit Period: ☐ 2 Years
☐ 5 Years
☐ Reducing Benefit Duration

Optional Provisions: ☐ Cost of Living Adjustment ☐ Guaranteed Purchase

Business Overhead Expense Insurance

Select your monthly benefit: Enter a multiple of $100 $_____
The maximum monthly benefit amount is $15,000

Indicate your Elimination Period: ☐ 15 days ☐ 30 days

Billing Option

Select your billing frequency: ☐ Annually ☐ Semi-annually

About Existing or Applied for Insurance

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? ☐ Yes ☐ No If "Yes", please list:

Name of Company	Plan	Monthly Benefit	Benefit Period

Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ☐ Yes ☐ No
(If "yes", please indicate which coverage and date it will be terminated.) _____

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays.

1. Height _____feet _____inches Weight _____ pounds

	Yes	No
2. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
3. Are you now, or have you in the past 5 years, used tobacco in any form?	☐	☐
4. 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?	☐	☐
5. 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", specific "date(s) of conviction(s)" (month/day/year) _____	☐	☐
6. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐	☐
7. Are you now receiving or applying for any disability benefits, including worker's compensation?	☐	☐
8. 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.

9. 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? ☐ ☐
10. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:
    a. heart or cardiovascular disorder, stroke, circulatory disorder, or high blood pressure? ☐ ☐
    b. cancer, Hodgkin's disease, lymphoma, tumors, anemia, leukemia or other blood disorder? Indicate type_____ ☐ ☐
    c. diabetes? Your age at diagnosis? _____ ☐ Check if insulin treated ☐ ☐
    d. sleep apnea, asthma, COPD, emphysema or other lung disease? Indicate type_____ ☐ ☐
    e. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ ☐ ☐
    f. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ ☐ ☐
    g. mental illness, anxiety, depression, attempted suicide or nervous disorder? Indicate type _____ ☐ ☐
    h. memory loss, epilepsy, paralysis, seizures, dizziness, other neurological disorder Specify date of last seizure (month/year)_____ Indicate type_____ ☐ ☐
    i. multiple sclerosis, ALS, muscular dystrophy, lupus, scleroderma, auto immune disease or connective tissue disorder, or arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type_____? ☐ ☐
    j. back, neck, knee, Epstein-Barr, chronic fatigue syndrome or fibromyalgia, spinal, joint or other musculoskeletal disorder or carpal tunnel syndrome? ☐ ☐
    k. kidney, urinary tract, prostate disorder, thyroid or other gland disorder? Indicate type _____ ☐ ☐

If you answer "yes" to any of the above medical questions, please explain the details below.

Question #	Condition/Diagnosis	Date of Diagnosis/Treatment	Medication Prescribed?	Type of Treatment
			☐ Yes_____ ☐ No	

Treating Health Professional (Name/Address/Phone):

Question #	Condition/Diagnosis	Date of Diagnosis/Treatment	Medication Prescribed?	Type of Treatment
			☐ Yes_____ ☐ No	

Treating Health Professional (Name/Address/Phone):

Personal Physician (Name/Address/Phone)

Reason for Visit: _____

Prescribed Medications? ☐ Yes_____ ☐ No

Date Last Visit:

Condition/Diagnosis: _____

Attach and sign a sheet of paper if additional space is needed.

FRAUD WARNINGS

Before signing this application, 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.

Tennessee: 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.

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this application and declare that all information I have given 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.
2. I declare that I am actively at work, working at least 30 hours per week, on the date I am applying. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I have read the applicable Fraud Warning(s) provided in this application.

Sign Here _____ _____ _____
Your Signature | Print Name | Date Signed (MM/DD/YYYY)

Sign Here _____ _____ _____
Agent Signature | Print Name | Date Signed (MM/DD/YYYY)

AUTHORIZATION

This Authorization is in connection with an application for insurance and information required for underwriting and claim purposed for the proposed insured(s) ("member", spouse, and 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 place 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; Entire medical file for the last 5 years, including medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases and other similar information;
    - 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.
    - Any employer, business associate, financial institution, or government agency to give the Company any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

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 application for 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 a 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.
- A photocopy of this form is as valid as the original form. You have 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.

Sign Here	_____	_____	_____	_____
	Your Signature	Print Name	Date Signed (MM/DD/YYYY)	State / Country of Birth