MetLife
Attn: Worldwide Benefits
600 North King Street
Wilmington DE, 19801
USA Toll Free (Within U.S.): 1-800-451-1847
Direct: +1-302-661-8674
Email: metlifeworldwide@metlife.com
www.metlifeworldwide.com

EXCESS GROUP INSURANCE APPLICATION

(Late Entrants must also complete this form)

Policyholder / Employer Name: ☐ Group Policy Number: ☐

Coverage Requested (please check all that apply) ☐ Excess Group Life ☐ LTD

EMPLOYEE INFORMATION

*ALL Fields Must Be Completed or Application Will Be Returned

Employee Name: Email:

Current Mailing Address:

Title: Employee Phone Number: Date of Hire:

Annual Salary: $ Current Basic Life Amt: $ Current Supplemt Amt: $

APPLICANT INFORMATION

ALL Fields Must Be Completed or Application Will Be Returned

Insurance Requested is For: ☐ Employee ☐ Spouse ☐ Child

(A separate form must be completed for each applicant)

Applicant Name: Email:

Date of Birth: Height: Weight: ☐ Male ☐ Female

Place of Birth: Current Supplemental/Dependent Life Amount through Employer: $

Additional Amount of Supplemental Requested: $ Total Amount of Supplemental Requested: $

Yes	No	
☐	☐	1. Has the applicant ever had a request for life or disability insurance declined, postponed, rated or restricted in any way; or is there any insurance applications pending or being contemplated?
☐	☐	2a. Has applicant flown or taken instructions as a pilot or engaged in any kind of racing, scuba, or sky diving, hang gliding within the past 2 years, or does the applicant intend to?
☐	☐	2b. Does the applicant fly, other than regularly scheduled airlines?
☐	☐	3. Within the past five years has the applicant used amphetamines, narcotics, barbiturates, hallucinogens, or marijuana, or received treatment for drug or alcohol use?
☐	☐	4. Has applicant ever had or ever been treated for or told you had heart or blood vessel disease, high blood pressure, brain, nervous system, kidney, liver, or lung disease, cancer, diabetes, ulcer, alcoholism or drug abuse, venereal disease, any recent weight loss, or any other serious disorder?
☐	☐	5. Has applicant been treated or diagnosed by a physician for “AIDS” (Acquired Immune Deficiency Syndrome), “AIDS” related complex, or do you have enlarged lymph nodes?
☐	☐	6. Is the applicant presently taking any medication?

Coverage is underwritten by Delaware American Life Insurance Company

Name and Address of Personal Physician

Date Last Seen

Reason Last Seen

If answer to any question above is **"YES"**, please give particulars below including name and address of physician and date attended.

Authorization

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health (or of my dependant named as proposed applicant), to give Delaware American Life Insurance Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigation consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources except the Medical Information Bureau, to give such records or knowledge to any agency employed by Delaware American Life Insurance Company to collect and transmit such information.
2. I understand that this information will be used by Delaware American Life Insurance Company solely to determine eligibility for insurance.
3. I understand that I may revoke this authorization at anytime. I agree that such revocation will not affect any action which Delaware American Life Insurance Company has taken in reliance upon this authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
4. I know that I should retain a copy of this authorization for my records.
5. I agree that a photocopy of this authorization is as valid as the original.
6. To the best of my knowledge and belief, all statements made above are true and complete.
7. I understand that my application for group insurance will be accepted or declined on the basis of these statements, insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.
8. I authorize deductions from earning for the costs of this insurance.
9. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death. Please note that any application not signed and dated will be returned to the applicant.

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Authorized ______________________________
(Signature of Proposed Insured)

____
(Printed Name of Proposed Insured)

At ______________________________
(City and State)

On ______________________________
(Date)

Witnessed By ______________________________

PLEASE KEEP THIS FOR YOUR RECORDS

Notice to Applicant – Part One

In order to properly underwrite and administer your insurance program, Delaware American Life Insurance Company (we, our) and our reinsurers will rely heavily on information provided by you. We may also ask for medical or other information about you from others, such as medical professionals who have treated you and the Medical Information Bureau, Inc. In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization. Upon written request, you may have access to the information in your file (medical information will be disclosed only to your attending physician, if permitted by law). You also have the right to seek correction of information you believe to be inaccurate.

In making this application for insurance, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation. You also have the right to request to be interviewed in connection with preparation of such report. You may receive a copy of the report upon written request.

Notice to Applicant – Part Two

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a Company, the Bureau, upon request, will supply such company with information in its file. We or our reinsurers may also release information in our files to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file (medical information will be disclosed only to your attending physician, if permitted by law). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660. If you would like to receive a more detailed explanation of our procedures and your rights, please send your request to: Delaware American Life Insurance Company , Director of Medical Underwriting, Worldwide Benefits, P. O. Box 1449, Wilmington, DE 19899.