Supplemental Life Insurance Enrollment Form

DUKE UNIVERSITY
DUKE UNIVERSITY HEALTH SYSTEM

Marsh @WorkSolutions

MetLife®
Metropolitan Life Insurance Company

Duke University and Health System

SUPPLEMENTAL TERM LIFE ENROLLMENT FORM

EMPLOYEE NAME Last First Middle | SOCIAL SECURITY NO. | SEX (M/F)

ADDRESS No. Street | BIRTH DATE (Mo./Day/Yr.)

City | State | Zip | TITLE PREFERENCE ❑ MR. ❑ MRS. ❑ MS. | ANNUAL PAY

DAYTIME PHONE ( ) | HIRE DATE (Mo./Day/Yr.) | EMPLOYEE ID NUMBER

REASON FOR ENROLLMENT:
- ❑ New Coverage
- ❑ Family Status Change Date:___/___/___
- ❑ Change in Employment Other Than Coverage Amount
- ❑ New Hire First Time Eligible
- ❑ Change in Coverage Amount Required
- ❑ Late Enrollee (Statement of Health Required)

EMPLOYEE COVERAGE

A. Select the annual pay multiple that you desire. Your choice is from 1 to 8 times your annual pay to a maximum of $2.5 million. Plan minimum is 1 times your annual pay.*
❑ 1x ❑ 2x ❑ 3x ❑ 4x ❑ 5x ❑ 6x ❑ 7x ❑ 8x Annual pay (round up coverage to the next higher $10,000 increment if not an even $10,000.)

B. Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 12 months from the date of this enrollment form . . . . ❑ Yes ❑ No

***Special Note for TX residents:** Spouse/spousal equivalent and child coverage cannot exceed the employee's eligible coverage amount.

8

SPOUSE/SPOUSAL EQUIVALENT COVERAGE

A. Select coverage in $10,000 increments between $10,000 and $100,000.*
I elect the following coverage amount for my spouse/spousal equivalent: $ ___ ,000

B. Has your spouse/spousal equivalent smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within 12 months from the date of this enrollment form . . . . ❑ Yes ❑ No

NAME Last First M.I. | BIRTH DATE (Mo./Day/Yr.)

SOCIAL SECURITY NO. | SEX (M/F) | TITLE PREFERENCE ❑ MR. ❑ MRS. ❑ MS. | DEPENDENT TYPE ❑ SPOUSE ❑ SPOUSAL EQUIVALENT

For Spousal Equivalent coverage, you must complete a Domestic Partner Declaration or have registered as domestic partners or members of a civil union with a government agency or office where such registration is available.
- ❑ My Spousal Equivalent and I are registered as domestic partners or members of civil union as stated above.
- ❑ Send a Domestic Partner Declaration to the address listed on this form.

CHILD(REN) COVERAGE

A. Check box of desired coverage: ❑ $10,000

B. If you have a child listed that is age 19 or older, is s/he a full-time, unmarried student? . . . . ❑ Yes ❑ No

Note: List each unmarried dependent child up to age 19 (26 if a full-time student). Each child is covered for the same amount regardless of how many children are covered.

NAME Last First M.I. | BIRTH DATE (Mo./Day/Yr.) | SOCIAL SECURITY NO.

NAME Last First M.I. | BIRTH DATE (Mo./Day/Yr.) | SOCIAL SECURITY NO.

If you have more than two children, include their information on a separate sheet.

Marsh @WorkSolutions must be notified by you within the preceding 90 days when a child ceases to be eligible for dependent children's rider so that he/she may be given the opportunity to exercise the portability provision and change the dependent children's rider to an adult contract.

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ELIGIBILITY/UNDERWRITING INFORMATION

Answer the following questions if you are electing coverage.

	Employee	Spouse/Spousal Equivalent	Child
1. Has anyone been hospitalized during the 90 days (not including well-baby delivery) preceding the date of this enrollment form?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

If you answered "yes" to the above questions for any child, please name the child(ren):
1) ________________ 2) ________________ 3) ________________

If you answered "yes" for any child, are there other eligible children? . . . . ❑ Yes ❑ No

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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

If you are electing more than 2 times your annual pay or $500,000 in new coverage or if you are electing new coverage for your spouse/spousal equivalent that exceeds $10,000, you must answer the questions below.

	Employee	Spouse/Spousal Equivalent
2. Are you or your spouse/spousal equivalent now receiving or applying for any disability benefits, including workers' compensation?	❑ Yes ❑ No	❑ Yes ❑ No
3. Have you or your spouse/spousal equivalent ever been diagnosed or received medical treatment by a physician or other health care provider for:		
a) chest pain or heart trouble?	❑ Yes ❑ No	❑ Yes ❑ No
b) high blood pressure, stroke or circulatory disorder?	❑ Yes ❑ No	❑ Yes ❑ No
c) cancer or tumors?	❑ Yes ❑ No	❑ Yes ❑ No
d) anemia, leukemia or other blood disorder?	❑ Yes ❑ No	❑ Yes ❑ No

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS FORM.

		Employee	Spouse/Spousal Equivalent
4.	Have you or your spouse/spousal equivalent ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or the Human Immune Deficiency Virus (HIV) Infection?	❑ Yes ❑ No	❑ Yes ❑ No
5.	Have you or your spouse/spousal equivalent had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, or issued other than as applied for?	❑ Yes ❑ No	❑ Yes ❑ No

If you are enrolling after your initial eligibility period; if you answered "Yes" to any of the above questions for you, your spouse/spousal equivalent, or dependent children; if you are electing more than 4 times your annual pay or $750,000 in new coverage; or if you are electing new coverage for your spouse/spousal equivalent that exceeds $40,000, you must also complete a Statement of Health form for that individual. Marsh @WorkSolutions will mail a Statement of Health form to the address listed on this application for your completion.

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BENEFICIARY *No white outs or cross outs allowed in this section.* **Designation of Beneficiary. Percentages must total 100%.**

Employee Primary Beneficiary:		
Name	% Share	Relationship to Employee
Address		Birth Date (Mo./Day/Yr.)
Name	% Share	Relationship to Employee
Address		Birth Date (Mo./Day/Yr.)
If my primary beneficiary dies before me, I designate as contingent beneficiary:		
Name	% Share	Relationship to Employee
Address		Birth Date (Mo./Day/Yr.)
Name	% Share	Relationship to Employee
Address		Birth Date (Mo./Day/Yr.)

- Any payment will discharge our liability for the amount so paid.
- If enrolled for dependent life insurance, you are automatically the beneficiary for these coverages.
- If the beneficiary format is not sufficient for your needs, contact Marsh @WorkSolutions.
- If there is no beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid as defined in the Facility of Payment clause in the certificate.
- If there is more than one primary beneficiary, or more than one contingent beneficiary, they will share the death benefits equally, unless otherwise designated, or all will be paid to the survivor.
- I have the right to change this designation at any time.

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form. For any contributory life insurance only, the employee has been actively at work for at least 20 hours during the 7 calendar days preceding that date. If Hospitalized during the 90-day period preceding the date of this enrollment form, such insurance will not take effect until MetLife receives evidence of good health satisfactory to MetLife.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

I understand that if life coverage is not elected, or if the maximum coverage is not elected, evidence of good health satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

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: 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.

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature X ______________________ **Print Name** ______________________ **Date** ____________ **(Mo./Day/Yr.)**

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature X ______________________ **Print Name** ______________________ **Date** ____________ **(Mo./Day/Yr.)**

Other Signature X ______________________ **Print Name** ______________________ **Date** ____________ **(Mo./Day/Yr.)**

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How We Use and Disclose Information: We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. 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, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. 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; and
- 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 insurance or benefits.

How we use and disclose information depends on the products and services you have with us or are covered under. It also depends on laws that apply to those products and services. Unless restricted by law or by agreement, we may use what we know about you to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How 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.) In some circumstances we may disclose what we know about your health 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 if we give this information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to Metropolitan Life Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you have with us.

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- 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, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process information for us
- Perform research for us
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- 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; and
- 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 insurance or benefits.

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Supplemental Life Rate Table and Worksheet

Cost of Insurance Per $10,000 Coverage Unit

The cost of insurance rates are adjusted on the January 1 program anniversary to reflect the age of the insured adult. The rates may be adjusted to reflect the experience of the group, but not until January 1, 2012.

Monthly Cost of Insurance Table

Age* Employee/Spouse/ Spousal Equivalent Begins Coverage	Monthly Cost of Insurance Per $10,000 Coverage Unit Nonsmoker	Monthly Cost of Insurance Per $10,000 Coverage Unit Smoker
<30	0.33	$0.43
30 - 34	0.44	0.55
35 - 39	0.56	0.70
40 - 44	0.73	0.92
45 - 49	1.12	1.42
50 - 54	1.68	2.13
55 - 59	2.90	3.66
60 - 64	4.71	5.96
65 - 69	12.43	15.69

Dependent Children's Coverage: $1 monthly regardless of number of children

*Use issue age as of the prior January 1.

Rates for ages 70 and above are available by calling Marsh @WorkSolutions, Monday – Friday between 9 a.m. and 6 p.m. at (800) 552-9670.

See other side for convenient worksheet.

How Do I Enroll?

You may enroll by completing the enrollment form on the next page or online at www.personal-plans.com/duke. In order to meet the deadline to take advantage of less stringent underwriting guidelines, your enrollment from must be received by Marsh @ WorkSolutions within 60 days of eligibility. Please do not send form to the Benefits Office. Forms should be sent to March @ WorkSolution, P.O. Box 9122, Des Monies, IA 50306-9122. If you have questions regarding the Supplemental Life Insurance coverage, please contact Marsh @ WorkSolutions at (800) 552-9670.

Supplemental Life Worksheet

Call Marsh @WorkSolutions if you need assistance: (800) 552-9670

A. Choose Employment Coverage in a Multiple of Annual Pay.

Multiply 1, 2, 3, 4, 5, 6, 7, or 8 times annual pay and round up to the next higher $10,000 increment if the multiple of annual pay is not evenly divisible by $10,000, not to exceed a maximum coverage amount of $2,500,000.

Example: *employee, age 38 — nonsmoker*

Annual pay		Multiple of annual pay			Round up if not divisible by $10,000		Coverage amount		Coverage units		See Rate Table*		Monthly cost of insurance
$ 17,100	X	6	=	$ 102,600		=	$ 110,000	÷ $ 10,000 =	11	X	$ 0.56	=	$ 6.16
$	X		=	$		=	$	÷ $ 10,000 =		X	$	=	$

B. Select Spouse/Spousal Equivalent Coverage in $10,000 Units ($10,000 minimum).

Choose life insurance coverage in $10,000 units up to $100,000.

Example: *spouse/spousal equivalent, age 35 — nonsmoker*

Coverage amount		Coverage units		See Rate Table		Monthly cost of insurance
$ 50,000	÷ $ 10,000 =	5	X	$ 0.56	=	$ 2.80
$	÷ $ 10,000 =		X	$	=	$

C. Include $10,000 Dependent Children's Coverage.

Example: *three children* $ 1.00

To insure all eligible children for $10,000 per child, add a total of $1 monthly. Rate covers all eligible children, regardless of number. $ ______

D. Personal Summary

Employee Cost of Insurance .... $ ______

Spouse/Spousal Equivalent Cost of Insurance .... $ ______

Child(ren) .... $ ______

Total monthly payroll deduction .... $ ______

Return your enrollment form to Marsh @WorkSolutions.

**Use age as of the prior January 1.*

See other side for Rate Table.