Brighthouse FINANCIAL

Policy Number _____

Application for Life Insurance

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company
The Company indicated in this section is referred to as "**the Company**".

SECTION I - About the Proposed Insured

For Additional Insureds please complete the **Additional Insureds Supplement** form.

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

Country of Legal Residence | Date of Birth | E-Mail Address

Primary Phone Number | Alternate Phone Number | Preferred Time to Call From ☐AM ☐PM To ☐AM ☐PM | Sex ☐Male ☐Female

Place of Birth | Social Security or Tax ID Number | Earned Annual Income | Net Worth

☐U.S. Driver's License If not licensed, please indicate other form of ID: ☐Passport ☐Government Issued Photo ID
Issuer of ID | ID Number | Issue Date (if any) | Expiration Date (if any)

Name of Employer | Employer City | State | ZIP | Position/Duties

NON U.S. CITIZENS ONLY - Country of Citizenship | Green Card/Visa Type | Expiration Date

Country of Permanent Residence | ID Number | Years in the U.S.

SECTION II - About the Owner

⚠ Complete **ONLY** if the Owner is **NOT** the Proposed Insured.

☐ **OWNER - TRUST / BUSINESS ENTITY -** Name of Entity | Tax ID Number | Trustee / Owner State

☐Trust ☐Business Entity ☐Charity ☐Qualified Pension Plan Complete the appropriate **required** form(s).

☐ **OWNER - OTHER INDIVIDUAL**

First Name | Middle Name | Last Name

Permanent Address | City | State | Zip

Country of Legal Residence | Citizenship | Social Security or Tax ID Number | Date of Birth | Phone Number

E-Mail Address | Earned Annual Income | Net Worth | Relationship to Proposed Insured

Please indicate form of ID: ☐U.S. Driver's License ☐Passport ☐Government Issued Photo ID
Issuer of ID | ID Number | Issue Date (if any) | Expiration Date (if any)

☐**Check if ownership should revert to Insured upon Owner and Contingent Owner's deaths.**

SECTION III - About the Beneficiary / Beneficiaries

For additional Beneficiaries, use Section IX - Additional Information.

☐ Check here if the Owner is the Primary Beneficiary.

For Primary or Contingent Beneficiaries who are NOT the Owner, complete the table below.

Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured	Social Security Number (Optional)	Percentage of Proceeds (if not equal)
Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

☐ Check here to include all living and future natural or adopted children of the Proposed Insured as Contingent Beneficiaries. (Name all living children above.)

If a Custodian is acting on behalf of a minor Beneficiary listed above, please use **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

⚠ Federal law states that if someone with special needs has assets over $2,000, they may lose eligibility for government benefits.

SECTION IV - About Proposed Coverage

Check the desired coverage(s).

☐ Universal Life

Product Name

Face Amount*

Riders and Details

☐ Coverage Continuation (UL only)

Disability Waiver:
☐ Specified Premium _____
☐ Monthly Deduction (VUL only)

Death Benefit Option _____

Definition of Life Insurance:
☐ Guideline Premium Test
☐ Cash Value Accumulation Test

Planned Premium
Year 1 _____
Years 2 to _____ _____
Years ____ to ____ _____ (UL only)

☐ Variable Life

Product Name

Face Amount*

Riders and Details

☐ Disability Waiver
Dividend Options:
☐ Paid-Up Additions
☐ Other, please specify:

☐ Automatic Premium Loan Requested

☐ Whole Life

Product Name

Face Amount*

Riders and Details

Disability Waiver:
☐ Convertible ☐ Non-Convertible

☐ Term Life

Product Name

Face Amount*

Riders and Details

ⓘ For a full list of riders and options, please consult with your Producer.
Note: Some riders may require supplement forms to be completed.

For Variable Life products, please complete the **Variable Life Supplement** form.

* If Face Amount is equal to or exceeds $1,000,000, please complete the **Personal Financial Information** form.

ADDITIONAL OPTIONS

One Time (Single) Payment Amount _____

1035 Exchange Amount _____

Requested Policy Date _____

☐ Save Age

POLICY OPTIONS

☐ Alternate Policy: Product, Face Amount and Details _____

☐ Additional Policy: Product, Face Amount and Details _____

☐ Group Conversion Only
☐ Group Conversion Alternative

} Please complete the **Group Conversion Supplement** form for either choice.

SECTION V - About Existing or Applied for Insurance

Does the Proposed Insured or Owner have any existing or applied for life insurance or annuities with this or any other company?

Proposed Insured ☐ Yes ☐ No
Owner ☐ Yes ☐ No

If **YES**, please provide details of any existing or applied for **Life** Insurance on the **Proposed Insured** only.

Company	Amount of Insurance	Year of Issue	Status
			☐ Existing ☐ Applied For
			☐ Existing ☐ Applied For
			☐ Existing ☐ Applied For
			☐ Existing ☐ Applied For

In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan; withdrawal; lapse; reduction or redirection of premium/consideration; or change transaction (except conversions) involving an annuity or other life insurance? ☐ Yes ☐ No

If **YES,** complete **Replacement Questionnaire** AND any other state required replacement forms or 1035 exchange forms.

If Proposed Insured is financially dependent on another individual, indicate individual providing support:

☐ Spouse ☐ Child ☐ Parent ☐ Other _____

Amount of insurance on individual providing support. Existing Insurance _____ Insurance Applied For _____

If Proposed Insured is a minor, are all siblings equally insured? ☐ Yes ☐ No

If **NO**, please provide details: _____

SECTION VI - About Payment Information

PREMIUM PAYOR

☐ Proposed Insured ☐ Owner (If NOT the Proposed Insured.) ☐ Other (Complete the box below.)

Other Premium Payor Name _____ Social Security or Tax ID Number _____ Relationship to Proposed Insured or Owner _____

Reason this Person is the Payor _____

Permanent Address _____ City _____ State _____ Zip _____

PAYMENT MODE
(Check the appropriate ONE.)

Billing Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly Draft per Debit Authorization (See next page.)
☐ Monthly Draft per Existing Electronic Payment Number _____

Special Account: ☐ Government Allotment ☐ Salary Deduction ☐ List Bill
If Special Account, provide Employer Group Number (EGN) or List Bill Number _____

INITIAL PAYMENT
Amount Collected with Application _____

Method of Collection:
☐ Initial Premium by Electronic Funds Transfer (Must be at least a monthly amount.)
☐ Check (Must be at least 1/12 of an annual premium.)

SOURCE OF CURRENT AND FUTURE PAYMENTS (Check **ALL** that apply.)

☐ Earned Income ☐ Mutual Fund/Brokerage Account ☐ Money Market Fund ☐ Savings ☐ Loans
☐ Certificate of Deposit ☐ Use of Values in another Life Insurance/Annuity Contract ☐ Other _____

DEBIT AUTHORIZATION

⚠ Available only if the bank account holder is the Owner and/or Proposed Insured.

All others please complete the **Electronic Payment (EP) Account Agreement** form.

The undersigned ("I") hereby authorize the Company with whom I am completing this application to initiate debit entries through Metropolitan Life Insurance Company to the deposit account designated below, at the Financial Institution named below, using the Automated Clearing House. I authorize:

1. Monthly recurring debits; AND
2. Debits made from time to time, as I authorize.

This authorization is to remain in full force and effect until the Company has received written notification from me of its termination at such time and in such manner as to afford the Company and the Financial Institution a reasonable opportunity to act on it.

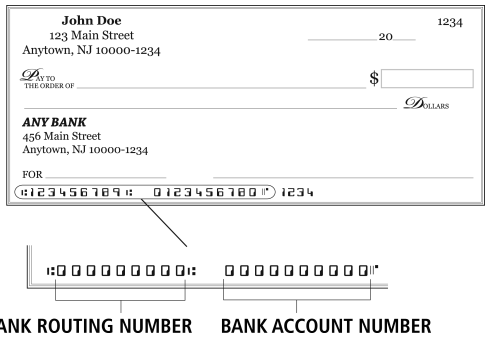
Monthly Debit Date: ☐ Issue Date of the Policy

☐ Debit Date on the _____ of each month

Bank Account Type: ☐ Checking ☐ Savings

Bank Routing Number _____ Bank Account Number _____

Name of Financial Institution _____



ⓘ Note: Please attach a voided check or deposit slip to Section IX - Additional Information.
We cannot establish banking services from starter checks, cash management, brokerage, or mutual fund checks. We cannot establish banking services from foreign banks UNLESS the check is being paid in U.S. Dollars through a U.S. correspondent bank (the U.S. correspondent bank name must be on the check).

SECTION VII - General Risk Questions

Use Section IX - Additional Information if necessary.

1. Within the past three years has the Proposed Insured flown in a plane other than as a passenger on a commercial airline or does he or she have plans for such activity within the next year? ☐ Yes ☐ No

If **YES**, please complete a separate **Aviation Risk Supplement** form for the Proposed Insured.

2. Within the past three years has the Proposed Insured participated in or does he or she plan to participate in **any** of the following? ☐ Yes ☐ No

- Underwater sports - SCUBA diving, skin diving, or similar activities
- Racing sports - motorcycle, auto, motor boat or similar activities
- Sky sports - skydiving, hang gliding, parachuting, ballooning or similar activities
- Rock or mountain climbing or similar activities
- Bungee jumping or similar activities

If **YES**, please complete a separate **Avocation Risk Supplement** form for the Proposed Insured.

3. Has the Proposed Insured **traveled** or **resided** outside the U.S. or Canada within the **past two years;** or does he or she plan to **travel** or **reside** outside the U.S or Canada within the **next two years?** ☐ Yes ☐ No

If **YES,** please provide details.

Past	Future	Duration (weeks)	Cities and Countries	Purpose
☐	☐			
☐	☐			
☐	☐			

4. Has the Proposed Insured **EVER** used tobacco or nicotine products in any form (e.g., cigars, cigarettes, cigarillos, pipes, chewing tobacco, nicotine patches, or nicotine gum)? If **YES,** please provide details. ☐ Yes ☐ No

Product(s)	Frequency / Amount	Date Last Used

5. In the past 10 years, has the Proposed Insured had a driver's license suspended or revoked, been convicted of DUI or DWI, or in the last five years had any moving violations? If **YES,** please provide date(s) and violation(s). ☐Yes ☐No

6. In the past 10 years, has the Proposed Insured been convicted of or pled Guilty or No Contest to a felony? If **YES,** list type of felony, state, and date of occurrence. ☐Yes ☐No

7. Is the Proposed Insured actively at work performing the usual duties of his or her occupation? If **NO,** please provide details. ☐Yes ☐No

SECTION VIII - Personal Physician

☐Check here if Proposed Insured does not have a personal physician.

Physician Name | Name of Practice or Clinic

Street Address | City | State | Zip

Phone Number | Date Last Consulted | Reason | Findings/Treatment Given/Medication Prescribed

SECTION IX - Additional Information

If more space is needed, attach additional sheet(s).

Certification / Agreement / Disclosure

Was a sales illustration provided for the life insurance policy as applied for? ☐ Yes ☐ No

A. If **Yes**, please choose one of the following:

☐ An illustration was signed and **matches the policy applied for**. It is included with this application.

☐ An illustration was shown or provided but is **different from the policy applied for**. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

☐ The sale was made using an illustration with Accelerated Payment.

☐ If illustration was **only shown on a computer screen**, check and complete the details in the box below.

An illustration was displayed on a computer screen. The displayed illustration **matches the policy applied for** but no printed copy of the illustration was provided. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. The illustration on the screen included the following personal and policy information:

1. Gender (as illustrated) ☐ Male ☐ Female ☐ Unisex
2. Age _____
3. Rating Class (e.g. Standard Non-smoker) _____ ☐ Non-smoker ☐ Smoker
4. Product Name (e.g. GAUL) _____
5. Face Amount _____
6. Dividend Option (Whole Life only) _____

B. If **No**, please choose one of the following:

☐ Producer certifies that a signed illustration is **not required** by law or the policy applied for is not illustrated in this state.

☐ **No illustration conforming to the policy** as applied for was shown or provided prior to or at the time of this application. An illustration conforming to the policy as issued will be provided no later than at the time of policy delivery.

Agreement / Disclosure

I have read this application for life insurance including any amendments and supplements and to the best of my knowledge and belief, all statements are true and complete. I also agree that:

- My statements in this application and any amendment(s), paramedical/medical exam and supplement(s) are the basis of any policy issued.
- This application and any amendment(s), paramedical/medical exam, and supplement(s) to this application will be attached to and become part of the new policy.
- No information will be deemed to have been given to the Company unless it is stated in this application, paramedical/medical exam, amendment(s), or any supplement(s).
- Only the Company's President, Vice-President or Secretary may: (a) make or change any contract of insurance; (b) make a binding promise about insurance; or (c) change or waive any term of an application, receipt, or policy.
- Except as stated in the Temporary Insurance Agreement and Receipt, no insurance will take effect until a policy is delivered to the Owner and the full first premium due is paid. It will only take effect at the time it is delivered if: (a) the condition of health of each person to be insured is the same as stated in the application; and (b) no person to be insured has received any medical advice or treatment from a medical practitioner since the date of the application.
- If I have requested a rider that provides an acceleration of death benefit, I have received the appropriate disclosure form.
- I understand that paying my insurance premiums more frequently than annually may result in a higher yearly out-of-pocket cost or different cash values.
- **If I intend to replace existing insurance or annuities, I have so indicated in the appropriate section of the application.**
- **I have received the Company's Privacy Notice and the Life Insurance Buyer's Guide.**
- **If I was required to sign a Notice and Consent for HIV Testing, I have received a copy of that Notice.**

Taxpayer Identification Number Certification

Under penalties of perjury, I, the Owner, certify that:

- The number shown in this application is my correct taxpayer identification number, and I am not subject to backup withholding because:
  (a) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; **or**
  (b) the IRS has notified me that I am not subject to backup withholding.
  (If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)
- I am a U.S. citizen or a U.S. resident alien for tax purposes.
  (If you are not a U.S. citizen or a U.S. resident alien for tax purposes, please cross out this certification and complete form W-8BEN).

ⓘ **Please note:** The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Signatures

If not witnessing all signatures, witness should initial next to signature being witnessed and sign below.

Signature(s) of all Proposed Insured(s) | Date | Signed at City, State

▶ _____ _____ _____

▶ _____ _____ _____

(age 18 or over)

Please complete the **Additional Insureds Supplement** or **Child Rider Supplement** form(s) if applicable.

Signature(s) of all Owner(s) (If **NOT** the Proposed Insured.) | Date | Signed at City, State

▶ _____ _____ _____

▶ _____ _____ _____

(age 18 or over)

ⓘ If the Owner is a firm or corporation, include Officer's title with signature.

If Co-Owner or Custodian, please complete the **Co-Owner/Contingent Owner and UTMA Designations Supplement** form.

Signature of Parent or Guardian | Date | Signed at City, State

▶ _____ _____ _____

(If Owner or Proposed Insured is under 18, sign here. If not sign above.)

Witness to Signatures

Licensed Producer | Print Name of Producer

▶ _____ _____

Brighthouse FINANCIAL

Policy Number _____

Medical Supplement

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

This supplement will be attached to and become part of the application with which it is used.

SECTION I - Medical Questions

⚠ If more space is needed, attach additional sheet(s).

ⓘ If FULL PARAMEDICAL/MEDICAL EXAM is required, completion of this Medical Supplement form is **OPTIONAL.**

Proposed Insured - First Name _____ Middle Name _____ Last Name _____

1. Please provide Proposed Insured's height and weight: Height (ft. in.) _____ Weight (lbs.) _____

Has the Proposed Insured experienced a change in weight greater than 10 pounds in the past 12 months? ☐ Yes ☐ No

If **YES,** please specify: Pounds Lost _____ Pounds Gained _____ Reason _____

2. Has the Proposed Insured, within the last 10 years, been diagnosed, received treatment, or consulted with a health professional for any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ High Blood Pressure
B. ☐ Chest Pain
C. ☐ Heart Attack
D. ☐ Heart Murmur
E. ☐ Diabetes
F. ☐ High Cholesterol
G. ☐ Cancer / Tumor / Polyp
H. ☐ Asthma / Bronchitis
I. ☐ Emphysema
J. ☐ Sleep Apnea
K. ☐ Seizures
L. ☐ Stroke / TIA
M. ☐ Paralysis
N. ☐ Multiple Sclerosis
O. ☐ Parkinson's Disease
P. ☐ Alzheimer's Disease
Q. ☐ Memory Loss
R. ☐ Colitis
S. ☐ Cirrhosis
T. ☐ Hepatitis
U. ☐ Arthritis
V. ☐ Lupus
W. ☐ Anemia
X. ☐ Depression / Anxiety
Y. ☐ Eating Disorder

Letter	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

3. Other than as indicated above, has the Proposed Insured, within the last 10 years, had any disease or disorder of any of the following? If **YES**, please check **ALL** that apply and provide details in table below. ☐ Yes ☐ No

A. ☐ Heart
B. ☐ Arteries / Veins
C. ☐ Lungs / Respiratory System
D. ☐ Gastrointestinal / Digestive System
E. ☐ Liver / Pancreas
F. ☐ Kidney / Bladder
G. ☐ Prostate
H. ☐ Reproductive Organs
I. ☐ Brain / Nervous System
J. ☐ Blood
K. ☐ Lymph Nodes
L. ☐ Immune System
M. ☐ Thyroid / Other Glands
N. ☐ Eyes
O. ☐ Ears / Nose / Throat
P. ☐ Skin
Q. ☐ Muscles / Bones / Joints
R. ☐ Emotional / Psychological Disorder

Letter	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

4. Other than as indicated previously, within the past five years, has the Proposed Insured had any illness, injury, surgery, physical exam, consultation, or medical test (e.g. laboratory tests, EKG, etc.) or been a patient in a hospital or other medical facility? ☐ Yes ☐ No

5. Is the Proposed Insured currently receiving any treatment or taking any prescription or nonprescription medications or supplements, as prescribed by a member of the medical profession? ☐ Yes ☐ No

6. Does the Proposed Insured have any surgery, medical tests, treatment or visits with a health professional scheduled in the next six months? ☐ Yes ☐ No

7. Has the Proposed Insured ever been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

8. Has the Proposed Insured ever tested positive during a medical examination for life insurance for the AIDS Human Immunodeficiency Virus (HIV) or for antibodies to the AIDS (HIV) virus? ☐ Yes ☐ No

9. Has the Proposed Insured ever used cocaine, heroin, or other illicit drugs or controlled substances except as prescribed by a health professional? ☐ Yes ☐ No

10. Has the Proposed Insured ever sought, been advised to seek, or received counseling or treatment for the use of alcohol or drugs from a health professional or support group? ☐ Yes ☐ No

If **YES,** please provide details in table below for Questions 4 - 10.

Number	Name of Health Professional (Include City & State)	Date / Duration of Illness	Diagnosis / Treatment / Medication

SECTION II - Family History

Has a parent or sibling ever had: heart disease; coronary artery disease; vascular disease; stroke/cerebrovascular disease; diabetes; cancer; or kidney disease? If **YES,** please provide details in table below. ☐ Yes ☐ No

Relationship to Proposed Insured	Age(s) if Living	Age(s) at Death	State of Health (Specific Conditions) or Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			

Authorization

Company (Check the appropriate ONE.)
The Company indicated in this section is referred to as "**the Company**".

☐ Brighthouse Life Insurance Company
☐ New England Life Insurance Company

This form was designed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

For underwriting and claim settlement purposes regarding me or any child(ren) under the age of 18 named below,
I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any pharmacy or pharmacy-related service organization; any insurer; any consumer reporting agency; and the MIB Group, Inc. (MIB) to give the Company information about me or such child(ren), including:
  - personal information and data;
  - entire medical file for the last ten (10) years, including medical information, records and data (such as: office visits; patient treatment; hospitalization; drugs prescribed; medical test results; information about sexually transmitted diseases and other similar information);
  - information related to alcohol and drug abuse and treatment;
  - information, records and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immunodeficiency Virus (HIV) test results; and
  - information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company, or its reinsurers, to make a brief report of my personal health information to MIB.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give the Company any information that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data that the Company receives pursuant to this Authorization will be used and maintained by the Company as described in the Company's Privacy Notice, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any vendor who performs a business service for the Company on the insurance applied for or on existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans. Once disclosed to the Company, this information may no longer be subject to those laws or regulations.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- I am not required by law to sign this Authorization, but if I do not, the Company will not be able to underwrite my application for life insurance. Health care provider(s) or health care plan(s) asked to release information pursuant to this Authorization cannot condition treatment or payment for treatment or other benefits on my signing it.
- **This Authorization will end 24 months from the date on this form or sooner if prescribed by law. For claim settlement purposes, this Authorization shall remain valid for the duration of the claim unless prohibited by law if a claim is submitted within 24 months from the date on this form. I may revoke it at any time by writing to the Company, Brighthouse Financial Privacy, PO BOX 49781, Charlotte, NC 28277 and advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.**
- **I, or my authorized representative, have a right to receive a copy of this form.**
- **A photocopy of this form is as valid as the original form.**
- **I am entitled to receive a copy of the investigative consumer report.**

Signatures

Print Name of Proposed Insured — First | Middle | Last

Date of Birth

If Proposed Insured is under 18, the ☐ **Parent** or ☐ **Guardian** is to sign on line for such child.

▶ Signature of Proposed Insured

Date

Signed at City, State

As witness, I attest to having observed all parties sign in my presence.

▶ Witness to Signature

Producer Identification & Certification

⚠ **Incomplete information may delay your application.**

1. What is the purpose of insurance? (Check **ALL** that apply.)

☐ Estate Planning ☐ Charitable Giving ☐ Qualified Plan ☐ Mortgage Protection ☐ Buy/Sell
☐ Executive Bonus ☐ Split Dollar ☐ Private Split Dollar ☐ Deferred Compensation ☐ Key Person
☐ Business Needs - Other ☐ Income Protection ☐ Other _____

2. Method used to arrive at the Face Amount Recommendation?

☐ Profiles Needs Analysis ☐ Human Life Value ☐ GSIB Proposal ☐ Other _____

3. Was this sale made using an illustration with Accelerated Premium? If **YES,** please indicate number of years. ☐ Yes ____yrs. ☐ No

4. Is this insurance a replacement? ☐ Yes ☐ No

5. Have you completed and attached the required replacement forms? ☐ Yes ☐ No ☐ N/A

6. Have you attached the Internal Revenue Code Section 1035 form? ☐ Yes ☐ No ☐ N/A

7. Have the following documents been delivered:

Privacy Notice	☐ Yes	☐ No		Life Insurance Buyer's Guide	☐ Yes	☐ No	
Beneficiary Locator Form	☐ Yes	☐ No		Temporary Insurance Agreement and Receipt	☐ Yes	☐ No	☐ N/A
HIV Notice and Consent Form	☐ Yes	☐ No	☐ N/A	Military Disclosure	☐ Yes	☐ No	☐ N/A
Compensation Disclosure Notice*	☐ Yes	☐ No	☐ N/A	Current prospectus for variable products and riders	☐ Yes	☐ No	☐ N/A
Debit Authorization Disclosure	☐ Yes	☐ No	☐ N/A				
ABR/ADBR Disclosure Statement	☐ Yes	☐ No	☐ N/A	Additional Person Designated to Receive Lapse and Termination Notices	☐ Yes	☐ No	☐ N/A
Chronic Illness (ECB) Disclosure	☐ Yes	☐ No	☐ N/A				

*Only required for business sold by MetLife Auto & Home sales representatives.

8. Did you use only sales material approved for use by the appropriate Company? ☐ Yes ☐ No

9. Did you see all persons to be insured on the date the application was taken? ☐ Yes ☐ No If **NO,** why not? _____

10. Do any of the Beneficiaries (Primary or Contingent) or their dependents have special needs? ☐ Yes ☐ No

11. Are you related to the Proposed Insured(s)? ☐ Yes ☐ No If **YES,** indicate relationship _____

12. Does the Owner want electronic delivery of the policy and related documents, if available? ☐ Yes ☐ No

Certification of Owner Identity:

☐ I certify that I personally met with the Owner(s)/legal representative(s) of the entity and reviewed the appropriate identification documents. To the best of my knowledge the documents accurately reflect the identity of the Owner(s)/legal representatives of the entity.

☐ I did not meet in person with the Owner(s)/legal representative(s) of the entity or I was otherwise unable to personally review the Owner(s)/entity's identification documents. I certify that, to the best of my knowledge, the Owner(s)/entity's identification information provided by the legal representative(s) either by mail or phone is accurate.

I certify that I have truly and accurately recorded on all parts of this application the information supplied by the Proposed Insured(s) and/or the applicant(s). As noted in question #9 above, I have personally observed each Proposed Insured and applicant. Apart from any admissions recorded on the application or any additional comments that I have supplied to underwriting, each appears to me to be healthy. The purpose of this sale has been discussed with the Owner(s) and I believe this application to be an appropriate recommendation. If variable products or securities were discussed, I hold the appropriate licenses for such discussions.

Producer Name (Please Print FULL Name)	Sales Office/ Agency Number/ID	Producer Number/ID	Commission Split % 1st Year	Commission Split % Renewal	Amount of GDC (for MLD only)

Signatures

Name of Producer _____ ▶ Signature _____ Date _____

Registered Principal, Manager or Designee Name

_____ ▶ Signature _____ Date _____

I have personally reviewed this application for appropriateness of sale. The Producer was appropriately licensed and appointed on the date the application was signed.

Life Independent Producers ONLY Does the Producer wish to annualize commissions? ☐ Yes ☐ No
If YES, signature of Producer's Manager (GA/MGA/BGA) is required.

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Proposed Insured: _____ _____ _____

First Name | Middle Name | Last Name

Notice And Consent For HIV-Related Testing

Company Copy

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Insurer**".

☐ Brighthouse Life Insurance Company
1209 Orange Street, Wilmington, DE 19801

☐ New England Life Insurance Company
One Financial Center, Boston, MA 02111

THE HIV VIRUS AND AIDS

To evaluate your insurability, it is requested that you provide a blood or other bodily fluid sample for testing for the presence of HIV antibodies or antigens, as well as for other tests such as cholesterol, diabetes and immune disorders. The antibody test will determine the presence of antibodies to the human immunodeficiency virus (HIV), the virus associated with Acquired Immunodeficiency Syndrome (AIDS), a life-threatening disorder of the immune system. The HIV antigen test directly identifies AIDS viral particles. These tests are not tests for AIDS; AIDS can only be diagnosed by medical evaluation. By signing and dating this form, you agree that testing may be performed and that underwriting decisions will be based on the test results. You may refuse to be tested; however, such refusal may be used by the insurer as a reason to deny coverage.

COUNSELING/ANONYMOUS TESTING

Many public health organizations have recommended that before submitting to an HIV test, a person seek counseling to better understand the implications of the test. You may wish to consider counseling, at your expense, prior to being tested or to consult with your physician or local health department. You may also wish to be anonymously tested.

See reverse side for counseling information. For your information, HIV is transmitted: by sexual contact with an infected person; from an infected mother to her newborn infant; or by exposure to infected blood (as in needle sharing during intravenous drug use). HIV is not spread through casual contact, such as eating with, touching or kissing a person infected with the virus. Persons at high risk of contracting AIDS include: males who have had sexual contact with another male; intravenous drug users; hemophiliacs; and sexual contacts of any of these persons. A person may remain free of symptoms for years after becoming infected. It is thought that persons have a 25-50% chance of developing AIDS within 10 years of becoming infected.

THE TEST: PURPOSE AND ACCURACY

The HIV antibody test is a medically accepted three-test series which is extremely accurate and reliable and is performed by a licensed laboratory. It is not error free. Possible errors include:

a. False positives: the test may give a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: the test may give a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least four to 12 weeks for a positive test result to develop after a person is infected.

MEANING OF POSITIVE HIV TEST RESULT

A positive HIV test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system including AIDS or AIDS-related conditions. Federal authorities consider persons who are HIV antibody/antigen-positive to be infected with the AIDS virus and capable of infecting others. If you test positive, you should seek a follow-up visit with your personal physician and/or a public health clinic or an AIDS information organization. You may want to consider further independent testing.

SIDE EFFECTS

A positive HIV test result may cause you significant anxiety, and may also result in uninsurability for life, health, or disability insurance policies you may apply for now or in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

CONFIDENTIALITY

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed: to the proposed insured (unless state law requires disclosure only to a physician; see Notification section); to the person legally authorized to consent to the test; to a licensed physician, medical practitioner, or other person designated by the proposed insured; if your HIV test is other than normal, to the Medical Information Bureau (MIB), a national insurance data bank, using a non-specific code, indicating only an abnormal test, to assure confidentiality; for statistical reports that do not disclose the identity of any particular proposed insured; to employees, reinsurers, or contractors of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer; and to Insurer's legal counsel who needs such information to represent the Insurer effectively in matters concerning the proposed insured. Results will not otherwise be disclosed except as allowed by law or as authorized by you. Results will not be disclosed to your agent or broker. You may request by notice to the Insurer the names of the specific individuals or organizations that: will have access to your file; will receive a copy of your results; or will keep the test information in a data bank or other file.

NOTIFICATION

If your test results are negative, no routine notification will be sent to you unless you complete the following:

Name to whom to disclose negative test results:

_____

Address:

_____

If your HIV test results are other than normal, you or a person you designate may receive the results directly except in states that prohibit direct notification (see list below). In states that prohibit direct notification, if you do not name a physician, the Insurer must notify the health department who will then notify you. It is recommended that you designate a physician, health department, or local organization (see reverse side) to receive the test result because a trained person should deliver the information so that you can understand the meaning of the test result.

Physician, health department, or organization for reporting a positive test result:

_____

Address:

_____

PREVENTION

Persons who have a history of high-risk behavior should modify these behaviors to prevent getting or giving AIDS, regardless of whether or not they are tested. Specific important changes in behavior include safe sex practices (including latex condom use) and not sharing needles.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above in the Confidentiality and Notification sections.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent is valid for six months from the date signed unless revoked by me in writing. A revocation will not affect disclosures already made, but no further disclosure will be made thereafter without my express written consent.

Name of Proposed Insured (Please Print)

First _____ Middle _____ Last _____

Signature of Proposed Insured or Parent/Guardian

▶ _____

Date

_____

Witness

_____

Brighthouse
FINANCIAL

Temporary Insurance Agreement and Receipt

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

SECTION I - What Does Temporary Insurance Provide?

For those eligible, Temporary Insurance provides for a death benefit upon receipt of proof of death of the Proposed Insured(s). The Temporary Insurance death benefit will be for the amount of insurance (including riders) applied for on the life of the deceased Proposed Insured(s) named on the application bearing the date of this Receipt and the supplement(s) to that application (collectively the "Application"). The total death benefit under this Receipt and all other receipts issued by all the companies listed above will not be more than $1,000,000 for any Proposed Insured(s) ($2,000,000 for survivorship life policies).* However, there will be no death benefit provided for the first death on a survivorship policy, or if death is by suicide. The death benefit will be paid to the person who would have received payment under the policy, had it been issued.

If the health or insurability of the Proposed Insured(s) changes once Temporary Insurance has started, the Company will consider the health of the Proposed Insured(s) as of the date Temporary Insurance began in deciding whether to issue the policy applied for. If the Proposed Insured(s) should have a material change in health or insurability while Temporary Insurance is in effect, the total amount of insurance which may be issued under this Receipt and all other receipts will not be more than $1,000,000 ($2,000,000 for survivorship life policies).*

If there is a person to be insured under an applicant waiver of premium rider or benefit (an "Applicant"), this benefit or rider will be included in the policy issued on the life of the Proposed Insured(s) if an Applicant dies: 1. Other than by suicide; 2. Before the rider or benefit is declined by the Company; and 3. While Temporary Insurance is in effect on the life of the Proposed Insured(s).

Premiums under the policy will be waived under the terms of the rider or benefit applied for.

*Should there be more than one application or receipt for any person to be insured, the share for each application will be in the ratio that the amount applied for on that application bears to the total amount of insurance applied for under all such applications.

SECTION II - Who is Eligible for Temporary Insurance?

The Proposed Insured(s) under the policy applied for is/are eligible for Temporary Insurance, if EACH of the following is true:

1. The Application, its supplements and paramedical/medical exam; do not include any material misrepresentation. AND
2. The Proposed Insured(s) has/have never received medical treatment for or been diagnosed with: cancer; Human Immunodeficiency Virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); coronary artery disease; stroke; alcohol use; or drug use. AND
3. The Proposed Insured(s) is/are at least 14 days old.

SECTION III - When Does Temporary Insurance Start?

Coverage starts on the later of the date of this Receipt or (if required at the time the Application was completed by the Company's underwriting rules) the date of any medical examination of the Proposed Insured(s) provided that one of the following is satisfied on the date of the Application:

1. Payment by check of an amount of at least 1/12 of an annual premium; or
2. Payment of Initial Premium Draft per Electronic Funds Transfer; or
3. Properly completed salary deduction plan form(s); or
4. Properly completed government allotment form(s); or
5. If the life insurance applied for with the Application is to be part of a Qualified Plan under the Employee Retirement Income Security Act of 1974 "ERISA" (e.g. a Pension Plan, Profit Sharing Plan, or a 401(k) Plan) and the Proposed Owner is the trustee of the Qualified Plan and the Employer Group Number (EGN) assigned by the Company is entered in the appropriate space on the Application, and a copy of the Commission Disclosure forms is provided to the Proposed Owner.

If a check or draft is returned for insufficient funds it will not constitute payment and Temporary Insurance will not be in effect.

Temporary Insurance will be in effect, if it has not already ended under the terms of this Receipt, if a Proposed Insured dies: from an accident; within 30 days from the date of this Receipt; before the required medical exam described above is completed; and one of the above 5 items was received on the date of the Application.

SECTION IV - When Does Temporary Insurance End?

Temporary Insurance will end on the earliest of the following:

1. When coverage under a policy issued by the Company as a result of the Application takes effect.
2. When a policy issued by the Company as a result of the Application is not accepted.
3. When the Company offers to refund any payment received under this Receipt.
4. When the Company refunds any payment received under this Receipt.
5. The date the Proposed Insured(s) or an Applicant learns that either the Application has been declined or the Company has decided to terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
6. If the Application is for a Qualified Plan under ERISA, the Proposed Owner learns that either the Application has been declined or the Company has decided to terminate the Temporary Insurance, or five days from the date the Company mails to the Proposed Insured(s) or an Applicant, at the address on the Application, a notice that the Application has been declined.
7. One hundred and twenty (120) days from the date of this Receipt.

If no policy takes effect, any payment received will be refunded when Temporary Insurance ends.

SECTION V - Limitations on Authority

No one but the President, Vice-President or the Secretary of the Company may change or waive the terms of this Receipt.

Signatures

All Premium Checks must be made payable to the Company checked on top of page 1.
DO NOT MAKE CHECK PAYABLE TO THE AGENT. **DO NOT** LEAVE THE CHECK PAYEE BLANK.

Amount Collected _____

Method of Collection:

- ☐ Check (Must be at least 1/12 of an annual premium.)
- ☐ Initial Premium by Debit Authorization in application (Must be at least a monthly amount.)
- ☐ Initial Premium by EP Account Agreement form (Must be at least a monthly amount.)

Or receipt of:

- ☐ Salary Deduction Plan form(s)
- ☐ Government Allotment form(s)
- ☐ Qualified Plan form(s)

is acknowledged in connection with the Application made on this date in which the Proposed Insured(s) is/are: _____

and the plan of insurance is: _____ from _____
company

Receipt Date: _____ Title: _____ Sales Office: _____

▶ Producer Signature: _____

Date _____ Signed at City, State _____

Brighthouse Life Insurance Company
Wilmington, DE 19801

D. Burt Arrington, Secretary

New England Life Insurance Company
Boston, MA 02111

D. Burt Arrington, Secretary

Note: If you have not heard from the Company within 120 days from the date of this Receipt, please contact the Company's representative.

Brighthouse FINANCIAL

Policy/Case Number ____________________

Date ____________________

Beneficiary Locator

New England Life Insurance Company • Brighthouse Life Insurance Company of NY • Brighthouse Life Insurance Company

Help us to ensure timely payment to your beneficiaries. Please provide the requested information. This will help us to locate your beneficiaries at the time of claim. This form may not be used to change the information on the application. If you wish to make changes to the application, please contact us. Any information on this form that is in conflict with the application will be disregarded. If you need additional room, please use a second form.

Owner/Insured/Beneficiary Information

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

☐ **Owner** ☐ **Insured** ☐ **Beneficiary**

First Name ____________ Middle Name ____________ Last Name ____________

Address ____________ City ____________ State ____ Zip ____

Social Security Number ____________ Date of Birth ____________ Phone Number ____________

Owner/Insured/Beneficiary Information - continued

For non-individual owners and beneficiaries, please provide the telephone number of the contact person named on the application. For trusts, please also include the address of the trust.

Entity Name | **Phone Number**

Address | **City** | **State** | **Zip**

Entity Name | **Phone Number**

Address | **City** | **State** | **Zip**

Additional Space

Brighthouse FINANCIAL

Policy Number _____

Personal Financial Information Supplement

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

This supplement will be attached to and become part of the application with which it is used.

First Name: _____ Last Name: _____ Identity Type: (Check all that apply.) ☐ Insured ☐ Payor ☐ Owner

SECTION I - Income

Annual Earned Income (in US dollars as reported to the IRS)

Salary or Draw $_____

Bonus/Commissions $_____

Other Earnings $_____

Source (If government assistance, please provide details.) _____

Total Earned Income $_____

Spouse's Income $_____

Annual Unearned Income (in US dollars as reported to the IRS)

Dividends/Interest $_____

Net Rentals $_____

Other Unearned Income $_____

Source (If government assistance, please provide details.) _____

Total Unearned Income $_____

SECTION II - Assets

Assets (in US dollars)

Cash/Cash Equivalents $_____

Real Estate $_____

Business Equity $_____

Stocks $_____

Bonds $_____

Annuities $_____

Mutual Funds $_____

CD/Money Markets $_____

Foreign Assets (Note: if more than 20% of total assets are outside the US, supporting documentation may be requested.) $_____

Other Assets (Artwork and other personal property must have written appraisals available.) $_____

Total Assets $_____

SECTION III - Liabilities

Liabilities (in US dollars)

Mortgages $_____

Personal Loans $_____

Other $_____

Total Liabilities $_____

SECTION IV - Expenses

Expenses

Annual Recurring Expenses (e.g., rent mortgage, long-term debts, utilities, alimony or child support, etc.) $_____

"Special Expenses" (if any) (e.g., future, non-recurring expenses, such as home purchase/ remodeling, car purchase or repairs, education, medical expenses, etc.) (Blank fields for Special Expenses will be assumed to be $0.) $_____

Timeframe for Special Expenses (within how many years) (e.g., 1 year for home remodeling, 4 years for education, etc.)

_____ _____ _____

SECTION V

Net Worth (Total Assets minus Total Liabilities) $_____

Tax Bracket (%) _____

Liquid Net Worth (The amount of cash (including checking, savings, etc.), and assets that can be turned into cash quickly and easily. Include the amount of the initial premium payment and/or lump sum payment for this coverage. Exclude personal property, personal residence, real estate, business equity, home furnishings, autos and assets subject to substantial penalties/sales charges.) $_____

Brighthouse FINANCIAL

Case Number(s) if known _____
(For sales office use only)

Authorization to Release Health-Related Information to the Producer

New England Life Insurance Company Brighthouse Life Insurance Company

I authorize the insurance companies named above (collectively "Brighthouse Financial") to disclose information about me, including health-related information, to the insurance producer named below for the purpose of providing me with additional information regarding the underwriting decision(s) made in connection with any application(s) I submit to any of the insurance companies named above for Life Insurance, Disability Income Insurance or Long-Term Care Insurance.

Print Name of Producer

First _____ Middle _____ Last _____

Print Business Address of Producer _____ City _____ State ☐ Zip _____

The **types of information that may be disclosed** by Brighthouse Financial pursuant to this Authorization include information contained in medical records such as test results, and data on my medical care, treatment or surgery and prescription medicines. Additional information that may be disclosed includes information regarding treatment for sexually transmitted diseases, mental illness, psychiatric or psychological disorders and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information regarding HIV test results, AIDS and HIV related conditions will not be disclosed under the terms of this Authorization.

In no event will information regarding your health history be disclosed if prohibited by applicable law.

I understand that:

- **I am not required to sign this Authorization as a condition of my application for insurance from Brighthouse Financial.**
- **Signing, not signing or revoking this Authorization will not affect my treatment or my payment, enrollment, or eligibility for Brighthouse Financial insurance.**

I further understand that:

- This Authorization will cover applications for the products indicated above submitted to any of the insurance companies named above during the next 12 months, beginning on the date this Authorization is signed.
- Information disclosed pursuant to this Authorization may no longer be subject to Brighthouse Financial privacy policy.
- Information that may have been subject to 42 CFR Part 2 or the privacy rules adopted and subsequently amended by the United States Department of Health and Human services pursuant to the Health Insurance Portability and Accountability Act of 1996 or other laws, once disclosed, may no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- This Authorization will be valid for 12 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to revoke this Authorization at any time and may do so by writing to: Brighthouse Financial, P.O. Box 489, Warwick, RI 02887. I further understand, however, that any action taken by Brighthouse Financial in reliance on this Authorization prior to receipt of my revocation by Brighthouse Financial will remain valid.
- I have a right to receive a copy of this Authorization.

A copy of this Authorization will be as valid as the original.

Signatures

Print Name of Proposed Insured Date of Birth

First _____ Middle _____ Last _____ _____

If Proposed Insured is under 18, the ☐ **Parent** or ☐ **Guardian** is to sign below for such child.

▶ Signature of Proposed Insured _____ Date _____ Signed at City _____ State ☐

As witness, I attest to having observed the party named above sign in my presence.

▶ Witness to Signature _____

Brighthouse
FINANCIAL

Notice Regarding Replacement of Life Insurance or Annuity

Company Copy

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one?

If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the agent or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

*or application or receipt number

Signatures

Applicant's Signature ▶ _____ Date _____

Agent's Signature ▶ _____ Date _____

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Brighthouse
FINANCIAL

Notice Regarding Replacement of Life Insurance or Annuity

Applicant Copy

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

REPLACING YOUR LIFE INSURANCE OR ANNUITY?

Are you thinking about buying a new life insurance policy or annuity and discontinuing or changing an existing one?

If you are, your decision could be a good one - or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits.

Make sure you understand the facts. You should ask the agent or company that sold you your existing policy to give you information about it.

Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

The following policy(ies) may be replaced as a result of this transaction:

Insurer as it appears on the policy	Insured as it appears on the policy	Policy Number*

*or application or receipt number

Signatures

Applicant's Signature ▶ _____ Date _____

Agent's Signature ▶ _____ Date _____

Brighthouse
FINANCIAL

Supplement to the California "Notice Regarding Replacement" Form

Company Copy

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company
The Company indicated in this section is referred to as "**the Company**".

USE ONLY FOR SAME COMPANY REPLACEMENT

Name of Proposed Insured: First _____ Middle _____ Last _____

Existing Policy # _____

Policy Information as of (Date) _____

GENERAL INFORMATION	**Existing Life Insurance/Annuity**	Proposed Life Insurance	Proposed Annuity
Basic Policy Type/Insured			
Rider 1: Type/Insured			
Rider 2: Type/Insured			
Rider 3: Type/Insured			
Rider 4: Type/Insured			
Issue Age			
Issue Date			
Contestability Period Expires			
Suicide Clause Expires			

PREMIUM DATA/ DEATH BENEFITS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Basic Policy Premium (1)				
Annual Target Premium				
Rider 1 Premium				
Rider 2 Premium				
Rider 3 Premium				
Rider 4 Premium				
Total Premium				
Basic Policy Death Benefit (2)				
Div. Adds. Death Benefit (AI)				
Rider 1 Death Benefit				
Rider 2 Death Benefit				
Rider 3 Death Benefit				
Rider 4 Death Benefit				

CASH VALUES/DIVIDENDS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Guaranteed Cash Value (Trad.)				
Accumulation Fund (UL/ULII/Annuities)				
Accumulated Dividends (DWI)				
Cash Value of Div. Adds. (AI)				
PUAR Cash Value				
Policy Loan				
Loan Interest Rate %				

Additional Comments _____

Notes: If your policy is not issued as applied for, another form will be provided.

1. **For universal life policies indicate the total amount being paid annually.**
2. **Basic Policy Death Benefit represents the face value of your life insurance policy. The actual death benefit payable may be increased by dividends with interest (DWI) and decreased by any outstanding indebtedness, plus accrued loan interest, on the policy.**

Applicant's Signature ▶ _____

Agent's Signature ▶ _____

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Brighthouse
FINANCIAL

Supplement to the California "Notice Regarding Replacement" Form

Applicant Copy

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

USE ONLY FOR SAME COMPANY REPLACEMENT

Name of Proposed Insured: First _____ Middle _____ Last _____

Existing Policy # _____

Policy Information as of (Date) _____

GENERAL INFORMATION	**Existing Life Insurance/Annuity**	Proposed Life Insurance	Proposed Annuity
Basic Policy Type/Insured			
Rider 1: Type/Insured			
Rider 2: Type/Insured			
Rider 3: Type/Insured			
Rider 4: Type/Insured			
Issue Age			
Issue Date			
Contestability Period Expires			
Suicide Clause Expires			

PREMIUM DATA/ DEATH BENEFITS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Basic Policy Premium (1)				
Annual Target Premium				
Rider 1 Premium				
Rider 2 Premium				
Rider 3 Premium				
Rider 4 Premium				
Total Premium				
Basic Policy Death Benefit (2)				
Div. Adds. Death Benefit (AI)				
Rider 1 Death Benefit				
Rider 2 Death Benefit				
Rider 3 Death Benefit				
Rider 4 Death Benefit				

CASH VALUES/DIVIDENDS	**Existing Life Insurance/Annuity** Immediately Before	Immediately After	Proposed Life Insurance	Proposed Annuity
Guaranteed Cash Value (Trad.)				
Accumulation Fund (UL/ULII/Annuities)				
Accumulated Dividends (DWI)				
Cash Value of Div. Adds. (AI)				
PUAR Cash Value				
Policy Loan				
Loan Interest Rate %				

Additional Comments _____

Notes: If your policy is not issued as applied for, another form will be provided.

1. **For universal life policies indicate the total amount being paid annually.**
2. **Basic Policy Death Benefit represents the face value of your life insurance policy. The actual death benefit payable may be increased by dividends with interest (DWI) and decreased by any outstanding indebtedness, plus accrued loan interest, on the policy.**

Applicant's Signature ▶ _____

Agent's Signature ▶ _____

Brighthouse FINANCIAL

Sales Material Disclosure Form For Replacement of Life Insurance or Annuities

Administrative Office Copy

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ New England Life Insurance Company ☐ Brighthouse Life Insurance Company

Policy/Contract Application Number

Case Number

Proposed Insured/Annuitant

First Middle Last

Financial Services Representative/Producer

	Sales Material Title	Form Number or LD Approval Number
1.		
2.		
3.		
4.		
5.		

Please attach another Disclosure Form for any additional sales material.

☐ No sales material other than a sales illustration was used in this sales. (Check box if applicable.)

Please Remember:

- Copies of the sales illustration or certification and any individualized or other sales material used in the sale must be submitted with the application.
- The original or a copy of all sales material used during the sale of the policy or contract indicated above must be left with the applicant.
- Electronically presented sales material must be provided to the owner in printed form no later than at the time of delivery of the policy or contract.

	Producer Name (print)	Producer Signature	Date
▶			
▶			

Brighthouse FINANCIAL

Sales Material Disclosure Form For Replacement of Life Insurance or Annuities

Applicant's Copy

Company (Check the appropriate ONE.) ☐ New England Life Insurance Company ☐ Brighthouse Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

Policy/Contract Application Number

Case Number

Proposed Insured/Annuitant

First Middle Last

Financial Services Representative/Producer

	Sales Material Title	Form Number or LD Approval Number
1.		
2.		
3.		
4.		
5.		

Please attach another Disclosure Form for any additional sales material.

☐ No sales material other than a sales illustration was used in this sales. (Check box if applicable.)

Please Remember:

- Copies of the sales illustration or certification and any individualized or other sales material used in the sale must be submitted with the application.
- The original or a copy of all sales material used during the sale of the policy or contract indicated above must be left with the applicant.
- Electronically presented sales material must be provided to the owner in printed form no later than at the time of delivery of the policy or contract.

	Producer Name (print)	Producer Signature	Date
▶			
▶			

Brighthouse FINANCIAL

Policy Number _____

Replacement Questionnaire

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ General American Life Insurance Company ☐ Brighthouse Life Insurance Company
☐ New England Life Insurance Company

SECTION I - Canceling or Altering an Existing Policy or Contract

Insurer Name	Insured or Annuitant name on Policy or Contract	Plan Type*	Policy or Contract Number	Issue Date	Face Amount (Only)	Future Premium Payment Status**	Check if 1035
							☐
							☐
							☐
							☐

*Policy Plan Type:
PERM - Any Permanent Life which is not Universal Life or Variable Life
ENDW - Endowment
TERM - Term
UNIV - Universal Life
VARI - Variable Life
FANN - Fixed Annuity
IANN - Indexed Annuity
VUNI - Variable Universal Life
VANN - Variable Annuity

** Future Premium Payment Status:
A - Pay limited number of premiums out of pocket, then use values in the policy
B - Existing or future policy values and/or value of future dividends
C - The out-of-pocket premiums will be suspended or reduced. **NOTE: Please provide a copy of the illustration.**
D - Premium payments will be discontinued. Policy will operate under its nonpayment of premiums option.
E - Continue to pay premiums out of pocket
F - Surrender or Cancel
G- Other – Please explain _____

Signatures

I agree that this proposed replacement is in the best interest of the owner. Any state required documentation has been provided to the owner.

Producer's Signature ▶ _____ Producer Printed Name _____ Date _____

Brighthouse
FINANCIAL

Acceleration of Death Benefit Rider (ADBR)
Summary and Disclosure Statement

Company (Check the appropriate ONE.) ☐ Brighthouse Life Insurance Company ☐ New England Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

This Summary and Disclosure Statement gives a brief description of the important features of the Rider. This is not an insurance contract and only the actual provisions of the Rider will control. The Rider itself sets forth in detail the rights and obligations of both you and the Company. It is, therefore, very important that you READ THE RIDER CAREFULLY.

TAX CONSEQUENCES

In general, the receipt of benefits under the Rider is not subject to Federal income tax. You should consult a personal tax advisor to see how benefits will be treated based on your specific facts and circumstances.

AVAILABILITY

An Accelerated Death Benefit is available if the Insured is terminally ill, subject to the terms of the Rider. The Rider provides for the partial or full acceleration of the Eligible Proceeds of the Policy.

ELIGIBLE PROCEEDS

Eligible Proceeds equal: the Policy proceeds as defined in the Policy; less any face amount provided by a Supplemental Coverage Term Rider; plus any amount of benefit provided by a rider that we consent to apply to an Accelerated Death Benefit. Eligible Proceeds will be calculated as of the date we receive a request for the Accelerated Death Benefit.

AMOUNT OF ACCELERATED DEATH BENEFIT

We will compute the Accelerated Death Benefit based on the following:

1. The amount of Eligible Proceeds you choose to accelerate;
2. Reduced life expectancy;
3. A processing charge not to exceed $150; and
4. An Interest Rate no greater than the greater of:
   a. The current yield on 90 day treasury bills; and
   b. The current maximum statutory adjustable policy loan interest rate.

PAYMENT OF AN ACCELERATED DEATH BENEFIT

Unless otherwise requested, we will pay the Accelerated Death Benefit in one sum or by placing the amount in an account that earns interest. The Owner will have immediate access to all or any part of the account.

EFFECT OF ACCELERATION

If **part** of the Eligible Proceeds are applied to the Accelerated Death Benefit, any policy values and the death benefit on the remaining policy will be reduced proportionately. We will provide full disclosure of the effects of the acceleration on the policy's cash value if any, death benefit, premiums, policy loans if available and face amount.

If **all** of the Eligible Proceeds are applied to the Accelerated Death Benefit, all policy benefits based on the Insured's life, except for any benefit for accidental death, will end. Any accidental death benefit will continue in force under the conditions stated in the Rider. Any riders that provide a benefit on the life of someone other than the Insured will stay in effect pursuant to their terms as if the Insured had died. No further cost for those riders will be payable.

SAMPLE ILLUSTRATION

The chart below is a generic example of how an accelerated payment might affect a policy. Your results will be different. The Owner has requested an acceleration payment equal to half of the Eligible Proceeds, or $97,500. This amount was calculated by subtracting the outstanding loan from the face amount of the Policy and taking half of that amount.

Accelerated Death Benefit would be calculated as follows: amount of Eligible Proceeds requested to accelerate, less actuarial discount for interest and reduced life expectancy and less the processing charge.

$ 97,500- $5,301- $150 = $ 92,049.

	Before	After
Face Amount:	$200,000	$100,000
Cash Value:	$8,000	$4,000
Outstanding Policy Loan:	$5,000	$2,500
Annual Premium:	$1,050	$525

COST

There is no additional premium charged to add this Rider to a policy. There will be a processing charge when an accelerated death benefit payment is made not to exceed $150.

GOVERNMENT ENTITLEMENTS

RECEIPT OF AN ACCELERATED BENEFIT MAY ADVERSELY AFFECT THE RECIPIENT'S ELIGIBILITY FOR MEDICAID, SUPPLEMENTAL SECURITY INCOME ("SSI") OR OTHER GOVERNMENT BENEFITS OR ENTITLEMENTS. Therefore, prior to exercising the acceleration, you should contact the appropriate social services agency (for example, the Medicaid Unit of the local Department of Public Welfare and Social Security Administration Office).

ACCELERATION

The acceleration can be processed if the Insured has a medical condition that is expected to result in death within 12 months. To make a claim, provide us with a statement signed by a physician that the Insured has a medical condition that is expected to result in death within 12 months. The physician may not be the Owner, the Insured, or a member of the Insured's family. We have the right to have the Insured examined at our expense by a physician we choose. This right will be exercised at places convenient to the Insured. The Rider outlines other conditions for acceleration.

LIMITS OF THE ACCELERATION OF DEATH BENEFIT RIDER

THE RIDER IS NOT HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE, AND IT IS NOT DESIGNED TO ELIMINATE THE NEED FOR SUCH COVERAGE. There are no restrictions or limits on the use of an accelerated death benefit payment. An accelerated death benefit payment may not be enough to cover your medical or other bills.

OTHER OPTIONS

Even though it is attached to the Policy, the Rider does not have to be exercised. The Rider provides you with an additional means of accessing cash under a life insurance policy, although it is not the only method of doing so. Alternatively, if provided for by your Policy, you may elect to receive a loan, a partial withdrawal or to make a surrender.

TERMINATION OF ACCELERATED DEATH BENEFIT

The Rider will terminate at the earliest of:

1. When an Accelerated Death Benefit is paid;
2. When the Policy to which this Rider is attached terminates; and
3. The monthly anniversary on or following receipt by us at our Home Office or any other office designated by us of your written request to terminate this Rider. We may require the Policy for endorsement.

The Rider will not take effect if its attachment to the Policy could cause the Policy to be disqualified as life insurance under the Internal Revenue Code.

Brighthouse
FINANCIAL

Notice And Consent For HIV-Related Testing

Proposed Insured Copy

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Insurer**".

☐ Brighthouse Life Insurance Company
1209 Orange Street, Wilmington, DE 19801

☐ New England Life Insurance Company
One Financial Center, Boston, MA 02111

THE HIV VIRUS AND AIDS

To evaluate your insurability, it is requested that you provide a blood or other bodily fluid sample for testing for the presence of HIV antibodies or antigens, as well as for other tests such as cholesterol, diabetes and immune disorders. The antibody test will determine the presence of antibodies to the human immunodeficiency virus (HIV), the virus associated with Acquired Immunodeficiency Syndrome (AIDS), a life-threatening disorder of the immune system. The HIV antigen test directly identifies AIDS viral particles. These tests are not tests for AIDS; AIDS can only be diagnosed by medical evaluation. By signing and dating this form, you agree that testing may be performed and that underwriting decisions will be based on the test results. You may refuse to be tested; however, such refusal may be used by the insurer as a reason to deny coverage.

COUNSELING/ANONYMOUS TESTING

Many public health organizations have recommended that before submitting to an HIV test, a person seek counseling to better understand the implications of the test. You may wish to consider counseling, at your expense, prior to being tested or to consult with your physician or local health department. You may also wish to be anonymously tested.

See reverse side for counseling information. For your information, HIV is transmitted: by sexual contact with an infected person; from an infected mother to her newborn infant; or by exposure to infected blood (as in needle sharing during intravenous drug use). HIV is not spread through casual contact, such as eating with, touching or kissing a person infected with the virus. Persons at high risk of contracting AIDS include: males who have had sexual contact with another male; intravenous drug users; hemophiliacs; and sexual contacts of any of these persons. A person may remain free of symptoms for years after becoming infected. It is thought that persons have a 25-50% chance of developing AIDS within 10 years of becoming infected.

THE TEST: PURPOSE AND ACCURACY

The HIV antibody test is a medically accepted three-test series which is extremely accurate and reliable and is performed by a licensed laboratory. It is not error free. Possible errors include:

a. False positives: the test may give a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: the test may give a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least four to 12 weeks for a positive test result to develop after a person is infected.

MEANING OF POSITIVE HIV TEST RESULT

A positive HIV test result does not mean that you have AIDS but that you are at a significantly increased risk of developing problems with your immune system including AIDS or AIDS-related conditions. Federal authorities consider persons who are HIV antibody/antigen-positive to be infected with the AIDS virus and capable of infecting others. If you test positive, you should seek a follow-up visit with your personal physician and/or a public health clinic or an AIDS information organization. You may want to consider further independent testing.

SIDE EFFECTS

A positive HIV test result may cause you significant anxiety, and may also result in uninsurability for life, health, or disability insurance policies you may apply for now or in the future. Although prohibited by law, discrimination in housing, employment or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

CONFIDENTIALITY

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed: to the proposed insured (unless state law requires disclosure only to a physician; see Notification section); to the person legally authorized to consent to the test; to a licensed physician, medical practitioner, or other person designated by the proposed insured; if your HIV test is other than normal, to the Medical Information Bureau (MIB), a national insurance data bank, using a non-specific code, indicating only an abnormal test, to assure confidentiality; for statistical reports that do not disclose the identity of any particular proposed insured; to employees, reinsurers, or contractors of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer; and to Insurer's legal counsel who needs such information to represent the Insurer effectively in matters concerning the proposed insured. Results will not otherwise be disclosed except as allowed by law or as authorized by you. Results will not be disclosed to your agent or broker. You may request by notice to the Insurer the names of the specific individuals or organizations that: will have access to your file; will receive a copy of your results; or will keep the test information in a data bank or other file.

NOTIFICATION

If your test results are negative, no routine notification will be sent to you unless you complete the following:

Name to whom to disclose negative test results:

_____

Address:

_____

If your HIV test results are other than normal, you or a person you designate may receive the results directly except in states that prohibit direct notification (see list below). In states that prohibit direct notification, if you do not name a physician, the Insurer must notify the health department who will then notify you. It is recommended that you designate a physician, health department, or local organization (see reverse side) to receive the test result because a trained person should deliver the information so that you can understand the meaning of the test result.

Physician, health department, or organization for reporting a positive test result:

_____

Address:

_____

PREVENTION

Persons who have a history of high-risk behavior should modify these behaviors to prevent getting or giving AIDS, regardless of whether or not they are tested. Specific important changes in behavior include safe sex practices (including latex condom use) and not sharing needles.

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above in the Confidentiality and Notification sections.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. This consent is valid for six months from the date signed unless revoked by me in writing. A revocation will not affect disclosures already made, but no further disclosure will be made thereafter without my express written consent.

Counseling Information about HIV testing and AIDS can be obtained by contacting your private physician, a public clinic, your local county health department or an AIDS information organization in your city. Certain state hotline numbers are listed below.

IN CALIFORNIA:

The San Francisco AIDS Foundation at	415-864-5855
The AIDS Project Los Angeles at	213-380-2000
The San Diego AIDS Project at	619-548-0300
The AIDS Project - East Bay at	415-420-8181
AIDS Services Foundation of Orange County at	714-646-0411
ARIS Project at	408-370-3272
Central Valley Aids Team at	209-264-2436
Sacramento Aids Foundation at	916-448-2437

In the event the result is positive, you are urged to contact a private physician, County Health Department, State Department of Health Services, local medical society or alternative test site for appropriate counseling. Any result sent directly to you will be sent by registered mail with delivery restricted only to you.

IN HAWAII:

Hilo at 933-4678
Kuna at 322-9705
Maui at 243-5075
Lanai at 565-6411
Molokai at 553-3145
Kauai at 822-3830

IN MONTANA:

If you prefer, anonymous testing is available. Information concerning locations of anonymous testing sites can be obtained from the Department of Health and Environmental Sciences of Montana, your local health department or by calling 1-800-233-6668.

IN NEBRASKA:

Nebraska AIDS Project at	1-800-782-2437
AIDS Action Line at	1-800-235-2331

IN RHODE ISLAND:

Rhode Island Department of Health, Office of AIDS/STD at	401-222-2320
Rhode Island Project AIDS Hotline at	1-800-726-3010

IN VIRGINIA:

Virginia Health Department at	1-800-533-4148

Personal face-to-face counseling is available.

IN WASHINGTON:

A list of counseling sites is available from the insurer. Contact the Underwriting Department or contact the Washington State Office of Prevention and Education Services HIV Antibody Testing/Counseling Services at 206-586-0426.

States that prohibit notifying the proposed insured directly of a positive HIV test result:

Alabama, Colorado, Delaware, Florida, Montana, and Washington.

Brighthouse FINANCIAL

Bank Draft Disclosure

SECTION I: Automatic Withdrawals

- Recurring withdrawals will not start unless the policy/contract is in force.
- This document applies to the following companies: Brighthouse Life Insurance Company, Brighthouse Life Insurance Company of NY, New England Life Insurance Company, referred to as "Brighthouse Financial".
- All withdrawals authorized will appear on your bank statement as "Brighthouse Financial" or "Brighthouse Fin."
- If the payment withdrawal date selected falls on a weekend, a holiday, or, in a shorter month, if the date selected is 29-31, the account will be billed on the next business day.
- By authorizing automatic withdrawals, Brighthouse Financial established a Brighthouse Financial Electronic Payment Account ("EP Account") for you. The EP Account is a payment method available to pay for policies/contracts issued or sold by Brighthouse Financial companies. Once you have an EP Account, other Brighthouse Financial products can be included with this account so that payments can be withdrawn on the same date.

SECTION II: Multiple Payment Withdrawals

Multiple payments may be withdrawn when:

- More than one policy/contract payment is due or needed to bring your policy/contract up to date.
- You requested a life insurance/individual disability income policy be back-dated resulting in more than one payment due at time of issue.
- The withdrawal date selected is after the contract date for life insurance policies with flexible premiums.

  Note: Guarantees may be affected if payments are missed or delayed.

SECTION III: Initial Premium Advance Payment for Life Insurance and Individual Disability Income

This option will allow the advance payment to be withdrawn immediately at signing of an application or during the underwriting process. This option is available if the policy/contract applied for will be paid by recurring monthly withdrawal. The initial withdrawal is subject to the terms of the Temporary Insurance Agreement and/or Conditional Receipt.

SECTION IV: Ending the Withdrawal

The EP Account shall remain in full force and effect until one of the following occurs:

- You notify Brighthouse Financial of the termination of the EP Account. Brighthouse Financial requires notification of at least 2 business days before a scheduled payment to either terminate the EP or to prevent a scheduled payment.
- Brighthouse Financial notifies you of the termination of the EP Account.
- The policy(ies)/contract(s) is/are no longer in effect.
- The bank account used for withdrawals is closed or is otherwise terminated.

SECTION V: General Information

If you change your bank or the bank account that you use for monthly deductions, you must stop your current agreement and complete a new form.

- If you are not able to submit the new EP Agreement form in advance of the previously authorized draft date, please be sure to leave sufficient funds in your original account to cover the deduction for that month.
- To obtain a new form refer to contact information below.

Paying insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.

Please be sure to have adequate funds in your bank account to cover the total monthly deduction on the Debit Authorization Form.

- If there are inadequate funds, your payment(s) into the policy(ies)/contract(s) may not be made, or may be made late. Either situation could result in a life insurance policy losing certain guarantees or a life insurance/individual disability income policy lapsing.
- Please note that many banks charge their customer when there are inadequate funds for an electronic draft.

Based on the policy/contract, premiums can increase.

Should a policy/contract no longer be paid by electronic draft, premiums or payments will be payable at the most frequent mode of payment available for that policy/contract.

Brighthouse Financial will not consider refund requests until ten business days after the withdrawal.

If your mailing address changes, or if you want to determine the status of your policy and any guarantees, please contact your financial professional or call us at 1-800-638-5433.

Brighthouse FINANCIAL

Notice Regarding Standards For Medi-Cal Eligibility and Recovery

For Distribution by Insurers, Agents, and Brokers

Company (Check the appropriate ONE.) The Company indicated in this section is referred to as "**the Company**".

☐ New England Life Insurance Company ☐ Brighthouse Life Insurance Company

State of California—Health and Human Services Agency | California Department of Health Care Services

IF YOU OR YOUR SPOUSE ARE CONSIDERING PURCHASING A FINANCIAL PRODUCT BASED ON ITS TREATMENT UNDER THE MEDI-CAL PROGRAM, READ THIS IMPORTANT MESSAGE!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

Recovery

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

Unmarried Resident

An unmarried resident may be eligible for Medi-Cal benefits if he/she has less than $2,000 in countable resources.

The Medi-Cal recipient is allowed to keep from his/her monthly income a personal allowance of $35 plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share-of-cost.

Married Resident

Community Spouse Resource Allowance: If one spouse lives in a nursing facility and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than $115,920 in countable resources.

Minimum Monthly Maintenance Needs Allowance: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his/her individual monthly income, or $2,898 in monthly income, whichever is greater.

Fair Hearings and Court Orders

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than $115,920 in countable resources. The order also may allow the at-home spouse to retain more than $2,898 in monthly income.

Real and Personal Property Exemptions

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

Real Property Exemptions

- *One principal residence.* One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

  The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

- *Real property used in a business or trade.* Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

Personal Property and Other Exempt Assets

- *IRAs, KEOGHs, and other work-related pension plans.* These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal, and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.
- *Personal property used in a trade or business.*
- *One motor vehicle.*
- *Irrevocable burial trusts or irrevocable prepaid burial contracts.*

There may be other assets that may be exempt.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney that is not connected with the sale of this product.

Please note: If you seek Medi-Cal payment for nursing facility services, you may be ineligible for those services if payments from your annuity extend beyond your life expectancy based upon life expectancy tables adopted by the Department of Health Care Services for this purpose. To find out about these tables, you may contact your local county welfare department.

Finally, the Department of Health Care Services is currently refining its policy regarding the treatment of annuities when determining eligibility for nursing facility services. Any regulatory changes will only impact annuities that are purchased after the effective date of any regulatory amendments.

Different rules apply to annuities that are qualified retirement arrangements established pursuant to Title 26, Internal Revenue Code, Subtitle A, Chapter 1, Subchapter D, Part 1. In some circumstances, Medi-Cal does not count funds held in an IRA, Keogh, or other work-related retirement arrangement. To find out if Medi-Cal would count your IRA, Keogh, or work-related retirement arrangements, you may contact your local county welfare department.

Signatures

I have read the above notice and have received a copy.

Proposed Owner Signature — Date

▶ _____ _____

Spouse's Signature — Date

▶ _____ _____

Legal Representative Signature — Date

▶ _____ _____

Brighthouse FINANCIAL

Disclosure to Seniors (Prior to Prospecting Visit)

Company (Check the appropriate ONE.) ☐ New England Life Insurance Company ☐ Brighthouse Life Insurance Company

The Company indicated in this section is referred to as "**the Company**".

SECTION I - Agent Information

(as appears on California Insurance License)

First Name **Middle Name** **Last Name**

Address **City** **State** **Zip**

Insurance License Number **Telephone Number**

1. **I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following:**
   - ☐ **Life insurance, including annuities**
   - ☐ **Other insurance products:** _____
2. **You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.**
3. **You have the right to end the meeting at any time.**
4. **You have the right to contact the Department of Insurance for information, or to file a complaint.**

   California Consumer Communication Bureau:
   800-927-4357
   (Hearing Impaired): 800-482-4833
5. **The following individuals will be coming with me to your home:**

Full Name	Insurance License Information (if applicable)

I received this notice at least 24 hours, but not more than 14 days, prior to an initial meeting in my home.

Signature

Signature **Date**

▶ _____ _____

Brighthouse FINANCIAL

Policy Number _____

Additional Person Designated to Receive Lapse and Termination Notices

Company (Check the appropriate ONE.) ☐ New England Life Insurance Company ☐ Brighthouse Life Insurance Company

This form must be completed and returned with a new application for life insurance coverage.

(Owner/Applicant): I hereby designate the person listed below to receive duplicates of notices advising of pending lapse or termination of coverage due to nonpayment of premiums for the life insurance policy referenced above:

☐ I do not wish to name anyone at this time.

Designated Person:

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Primary Phone Number

_____

u _____ _____

Signature of Owner/Applicant Print Name of Owner/Applicant

_____ _____

Date Signed at City, State

Brighthouse FINANCIAL

Electronic Payment (EP) Account Agreement

Use this form to establish or change an electronic payment.

Company *(Check the appropriate ONE.)*
The Company indicated in this section is referred to as the "Company"**.**

☐ New England Life Insurance Company
☐ Brighthouse Life Insurance Company
☐ Brighthouse Life Insurance Company of NY

Things to know before you begin

- **Instructions:** Use this form to establish or change an electronic payment account as a payment method for policies and contracts issued by the companies listed above. Once you have established an EP Account, other products can be included with this account so that payments can be withdrawn on the same date from the same bank account.
- If you need assistance completing this form, please call your representative, sales office, or the appropriate number listed under How to Submit this Form.

Please complete this form in its entirety to avoid any delays in processing.

SECTION 1: Type of request

☐ New Authorization *(To make regular withdrawals)*
☐ Change of Bank Account *(Prior Authorization)*
☐ Add policy/contract to existing Electronic Payment Account # _____

SECTION 2: Bank account owner information

Primary Owner of the Bank Account: ☐ Individual or ☐ Business Entity

First Name	Middle Name	Last Name

Business Entity

Street Address

City	State	Zip

Joint Owner of the Bank Account:

First Name	Middle Name	Last Name

SECTION 3: Policy/Contract payment information

Please complete the following chart using a separate column for each policy/ contract.	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____	**Policy/Contract No.** _____
Recurring Payment Type: Please choose one or more of the following: Premium, Loan repayment, Annuity,PUAR, etc.				
Recurring Payment Amount: Amount to draft every month				
Relationship of Bank Account Owner to Policy/ Contract Owner: Please choose one of the following: Self, Spouse/ Domestic Partner, Parent, Trustee, Business Owner, Step Parent, Child, Grandparent, Employer, or Guardian. ** Please review Bank Draft Disclosure for additional information.*				
Initial Premium Advance Payment Amount: **Please review Bank Draft Disclosure for additional information.*				

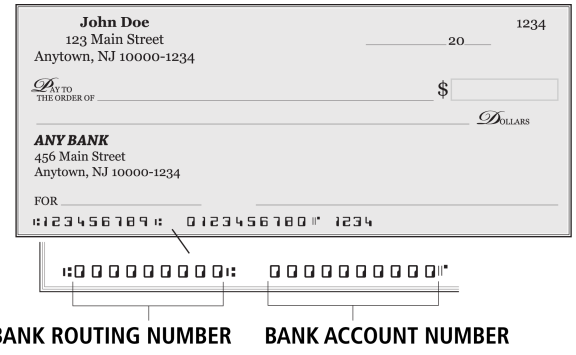
Withdrawal Date is the day of the month we will withdraw from your bank account. If you do not specify a date, monthly withdrawals will occur on the same day of the month as the issue date.

Please specify **only one** option: ☐ Issue Date of Policy/Contract ☐ Withdrawal on the _____ of each month

SECTION 4: Bank Information

Account Type: ☐ Checking ☐ Savings

We **CANNOT** establish electronic payments from some brokerage, mutual funds or from foreign bank accounts *(unless it is being paid in U.S. Dollars through a U. S. correspondent bank.)*



Banking Institution Routing Number

_____

Account Number

_____

Name of Bank

Bank Address & Branch where account is located

If this is a brokerage account, please provide Firm Name

SECTION 5: ACH withdrawal authorization

I, the Bank Account Holder, hereby authorize

1. Metropolitan Life Insurance Company, acting as a third party administrator or other service provider pursuant to one or more agreements with the companies named above, to initiate withdrawal entries to the deposit account designated above at the Bank named above, using the Automated Clearing House;
2. Monthly recurring withdrawals in the amount set forth in Section 3 above and such additional amounts that may be required under the terms and conditions of the relevant policy/contract; and
3. Withdrawals made from time to time, as I authorize.

I understand that:

1. The origination of electronic withdrawals to my account must comply with the provisions of U.S. law;
2. The Company requires notification of a least two business days before a scheduled payment to either terminate the EP account or to prevent a scheduled payment.
3. If payments are made for insurance premiums, paying insurance premiums monthly may result in a higher yearly out-of-pocket cost or different cash values.
4. Premiums may increase in accordance with the terms and conditions of the policy or contract. If I am not the owner of any policy or contract identified above, I will not receive advance notice of any change in the amount of any authorized withdrawal with respect to such policy or contract.
5. The owner of the policy or contract is responsible for ensuring that adequate premiums are paid to keep the policy/contract in force.

SECTION 6: Signatures

All Bank Account Owners must sign this form. Please sign as shown below:

A Partnership	The full name of the firm should be printed with the signature of all general partners *(not limited partners).*
A Sole Proprietorship	The full name of the business should be printed with the signature of the owner followed by the word “owner.”
A Trust	Signatures, followed by the word "Trustee," of all required Trustees. Also submit a Trust Certification, which is available from your representative, sales office, or the appropriate number listed under How to Submit This Form.
A Corporation	The signatures and titles of two authorized officers.
An Individual acting on Behalf of the Bank Account Owner	The full name of the Owner's fiduciary or agent and the legal documentation of the authority to act *(e.g., power of attorney, guardianship papers, etc.).*

By signing this document, I accept the terms of this EP Account Agreement.

Print Name of Individual Signing - First | Middle name | Last name

Title *(If you are acting in a representative capacity)* | Signed at City | State

Sign Here Signature of Owner of the Bank Account | Date *(mm/dd/yyyy)*

Print Name of Individual Signing - First | Middle name | Last name

Title *(If you are acting in a representative capacity)* | Signed at City | State

Sign Here Signature of Joint Owner of the Bank Account | Date *(mm/dd/yyyy)*

Before mailing, please include the following items:

• Banking Routing number, Account Number and Bank information • All required signatures • Policy/Contract Number • Relationships of the Bank Account Owner to the Policy/Contract Owner

For Sales Office Use Only Sales Office/Agency Number/Representative ID | Date

Sales Representative Name - First | Middle | Last

SECTION 7: How to submit this form

Return pages 1 through 3 of the completed form to the address or fax number listed below for the Company that issued the policy or contract. If policies or contracts are issued by more than one Company, return the completed form to any Company that issued at least one of the policies or contracts.

Issuing Company	Contact Phone Number	Fax Number	Address
Brighthouse Life Insurance Company Brighthouse Life Insurance Company of NY	1-800-638-5433	1-908-655-9581	P. O. Box 354, Warwick, RI 02887-0354
New England Life Insurance Company	1-800-638-5433	1-908-655-9582	P. O. Box 323, Warwick, RI 02887-0323
Annuity contracts issued by any of the Companies listed above	1-877-638-3279	1-877-547-9669	P. O. Box 10342, Des Moines, IA 50306-0342