

Election of Portable Coverage Form For Group Life Insurance Coverage

Important Information About MetLife's Portability Option

You're in a time of transition, and MetLife welcomes the opportunity to provide you and your dependents with an affordable option to continue the Group Life Insurance coverage that you had with your former plan.

Here are some highlights of your Portability option...

- **You can take coverage with you.** You may continue the same or lesser amount of life insurance coverage you had on yourself and your dependents at the time of your coverage termination through your former plan (See Part A of the Election Form). The minimum amount an employee can continue on a portable basis is \$20,000; the maximum is generally equal to the Life insurance coverage amount at the time of coverage termination or \$1,000,000, whichever is less.
- **Full protection for you and your family.** When you elect portable coverage, you will have these valuable features: MetLife's Total Control Account[®] (TCA) for you and your dependent(s) and Accelerated Benefits Option (ABO) for you and your dependent spouse.

It's easy to elect Portable coverage:

1. Complete the attached Election Form **within 31 days** from the date your benefits are terminated or reduced, **or** 45 days from the date this notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated or reduced.
2. Select the portable coverage amount for you and your dependents (see attached Election Form Part B).
3. Designate your beneficiary(ies) and provide the required signatures.
4. **Send your completed Election Form to: MetLife Recordkeeping Center, P. O. Box 6169, Utica, NY 13504-6169.**
5. Upon receipt of your completed Election Form, MetLife will send your initial monthly bill directly to your home address.

If you have any questions, require assistance in completing your Election Form, or wish to find out the cost of your portable coverage, you may phone our MetLife Recordkeeping Center toll-free at **1-866-492-6983**, between the hours of **8:00 a.m. and 8:00 p.m. (EST)**.

ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is either the Employer, TPA or MetLife.)

1. Immediately upon the Insured's termination of employment, complete Part A below and make two copies of this form.
2. Provide the Eligible Insured with the original or mail it to their last known address.
3. **Mail a copy of this form to MetLife Recordkeeping Center, P.O. Box 6169, Utica, NY 13504-6169.**
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER

Employer Name: Northrop Grumman		Group Report No.: 93471		Portable No.: (MetLife Use Only)	
Insured Coverage Termination Date:			Date of This Notice:		
Insured Name: (Last, First, Initial)			Social Security Number:		Date of Birth: Sex: (M/F)
Insured Mailing Address: (Street, City, State, Zip)				Insured Home Telephone No.:	
Annual Salary at Coverage Termination: \$		Reason for Termination:			
Has Coverage Been Assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify coverage assigned _____ and attach a copy of assignment form.					
Was the insured actively at work on the date of separation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Recordkeeper Name: _____					
Name of Person Completing Part A: _____ Telephone Number: _____					
Employer To Verify Insurance Amount(s) In Effect At Termination Date:					
<u>METLIFE INSURED COVERAGE AMOUNTS IN EFFECT:</u>					
		<u>Life Insurance Amount</u>			
Insured:					
• Optional Life		\$ _____			
Dependent Spouse:					
• Dependent Life		\$ _____			
Dependent Chil(dren):					
• Dependent Life		\$ _____			

ELECTION OF PORTABLE COVERAGE FORM (Continued)

If you are a resident of Minnesota, Oregon, South Dakota or Vermont, Portable Term coverage is not available to you. If you are a resident of the state of Michigan, there is a limit to the amount of coverage you are allowed to port. This limit applies to your combined Term Life coverages for a covered person, it does not apply to AD&D coverages. For specific details about this limit, contact the MetLife Recordkeeping Center 1-866-492-6983.

MetLife provides coverage under a Group Insurance policy (Policy Number 93211-G) issued to the Chase Manhattan Bank, N.A., as Trustee. All Portable Term coverage terminates when your premium payments cease, or January 1 of the year in which you attain age 80. Portable Term insurance does not provide payment for death caused by suicide within the first two years (one year in North Dakota) from the effective date of your coverage under your employer's Group Life Insurance benefit plan (except in Massachusetts, Missouri and Washington).

Part B – TO BE COMPLETED BY THE INSURED

<p>Insured Application Period: The Insured must apply for portable coverage within 31 days from the date benefits were terminated or reduced, or 45 days from the date this notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated or reduced.</p>	<p>You may continue coverage at the same amount you had at the time of coverage termination or at a lesser amount. The employee minimum is \$20,000; the maximum is equal to the life insurance amount at time of coverage termination or \$1,000,000, whichever is less. At age 70, your coverage will be reduced by 50%.</p>
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Portable Insurance Amount(s) Requested (Please Round Coverage to the nearest thousand)

	<u>Same Amount</u>	<u>Decreased Amount</u> ¹	<u>No Coverage</u>
<p>Insured: ²</p> <ul style="list-style-type: none"> Optional Life <input type="checkbox"/> 		<p>\$ _____</p>	<input type="checkbox"/>
<p>Dependent Spouse: ³</p> <ul style="list-style-type: none"> Dependent Life <input type="checkbox"/> 		<p>\$ _____</p>	<input type="checkbox"/>
<p>Dependent Chil(dren): ³</p> <ul style="list-style-type: none"> Dependent Life <input type="checkbox"/> 		<p>\$ _____</p>	<input type="checkbox"/>

NOTE: All coverage amounts are subject to applicable state laws.

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attach a separate sheet of paper, signed and dated)

	Date of Birth (Mo./Day/Yr.)	Social Security No.
Spouse: _____	_____	_____
Child(ren): _____	_____	_____
_____	_____	_____
_____	_____	_____

- Specify the amount of coverage you prefer. The coverage amount selected may not exceed the coverage amount under the former plan.
- In order to elect Portable coverage, you must have had the selected coverage under the former plan.
- In order to elect Portable coverage for your dependent(s), if applicable, you must elect coverage for yourself. The amount of coverage elected must not exceed the amount elected for yourself. Spouse minimum is \$2,500 and the child minimum is \$1,000.

**ELECTION OF PORTABLE COVERAGE FORM (Continued)
TO BE COMPLETED BY THE INSURED (Continued)**

DESIGNATION OF BENEFICIARY FOR INSURED LIFE BENEFITS (The Dependent Life Benefits are Payable to the Insured)				
<input type="checkbox"/> I Designate as my Primary Beneficiary: <input type="checkbox"/> My Designation of Beneficiary is on a separate form which is signed, dated and attached.				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
TOTAL:				100%
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):				
Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
TOTAL:				100%
Unless designated otherwise, payment will be made in equal shares or all to the survivor. I RESERVE the right to change this designation at any time.				
Insured Signature: _____			Date of Signature _____ (Mo./Day/Yr.)	

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, or if you reside in one of the following states, note the following applicable warning:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

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

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

If you are applying for insurance under a policy issued in any state other than those listed above, or if you reside in any state other than those states listed above, note the following warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Insured/Assignee Signature:	Date:
Dependent Spouse Signature:	Date:
Dependent Child Signature (If over 18 years of age and/or a Michigan Resident):	Date:

RATE SHEET
Schedule of Monthly Portable Group Life Insurance Term Rates
For Insured and Dependents

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse's age as of December 31st, of the current calendar year. Rates are subject to change.

TABLE A
LIFE INSURANCE ONLY
MONTHLY TERM RATES

AGE	INSURED RATE	DEPENDENT SPOUSE RATE
15	\$0.106	\$0.106
16	\$0.120	\$0.120
17	\$0.129	\$0.129
18	\$0.137	\$0.137
19	\$0.141	\$0.141
20	\$0.142	\$0.142
21	\$0.153	\$0.153
22	\$0.146	\$0.146
23	\$0.131	\$0.131
24	\$0.122	\$0.122
25	\$0.115	\$0.115
26	\$0.115	\$0.115
27	\$0.107	\$0.107
28	\$0.107	\$0.107
29	\$0.107	\$0.107
30	\$0.107	\$0.107
31	\$0.107	\$0.107
32	\$0.115	\$0.115
33	\$0.115	\$0.115
34	\$0.122	\$0.122
35	\$0.131	\$0.131
36	\$0.138	\$0.138
37	\$0.153	\$0.153
38	\$0.168	\$0.168
39	\$0.184	\$0.184
40	\$0.202	\$0.202
41	\$0.224	\$0.224
42	\$0.248	\$0.248
43	\$0.275	\$0.275
44	\$0.302	\$0.302
45	\$0.334	\$0.334
46	\$0.370	\$0.370
47	\$0.410	\$0.410

AGE	INSURED RATE	DEPENDENT SPOUSE RATE
48	\$0.454	\$0.454
49	\$0.500	\$0.500
50	\$0.552	\$0.552
51	\$0.610	\$0.610
52	\$0.673	\$0.673
53	\$0.743	\$0.743
54	\$0.811	\$0.811
55	\$0.896	\$0.896
56	\$0.987	\$0.987
57	\$1.091	\$1.091
58	\$1.204	\$1.204
59	\$1.328	\$1.328
60	\$1.470	\$1.470
61	\$1.624	\$1.624
62	\$1.796	\$1.796
63	\$1.987	\$1.987
64	\$2.202	\$2.202
65	\$2.436	\$2.436
66	\$2.682	\$2.682
67	\$2.904	\$2.904
68	\$3.139	\$3.139
69	\$3.399	\$3.399
70	\$3.691	N/A
71	\$4.022	N/A
72	\$4.400	N/A
73	\$4.828	N/A
74	\$5.292	N/A
75	\$5.785	N/A
76	\$6.359	N/A
77	\$6.958	N/A
78	\$7.585	N/A
79	\$8.262	N/A

Example Calculation of Premium For Insured Only:

$$\frac{\$50,000}{\text{Amount of Coverage selected}} \div \$1,000 = \frac{50}{\text{\# of units}} \times \$0.334 = \$16.70 \text{ (Monthly Premium)}$$

Rate based on Age 45

TABLE B
LIFE INSURANCE ONLY
MONTHLY TERM RATES

AGE	DEPENDENT CHILD(REN) RATE
N/A	\$0.162

Please Note: The Dependent Child(ren) Rate is based on a flat monthly rate. Each child is covered for the same amount regardless of the number of children covered under the policy.

PRIVACY NOTICE

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

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

Metropolitan Life Insurance Company

Paragon Life Insurance Company

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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