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.

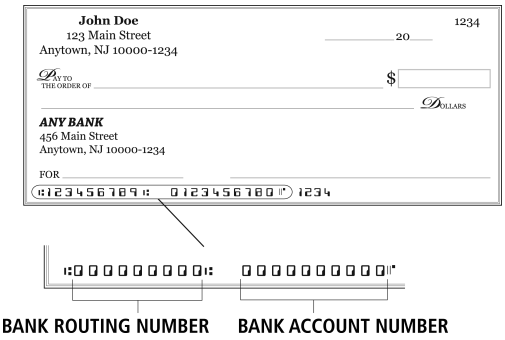
Monthly Debit Date: ☐ Issue Date of the Policy

☐ 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. Has the Proposed Insured **EVER** 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. Has the Proposed Insured **EVER** had an application for life, disability income or health insurance declined, postponed, rated or modified or required an extra premium? If **YES,** please provide details. ☐Yes ☐No

7. 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

8. 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.**

Fraud Warnings

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purposes of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance and civil damages. It is also unlawful for any insurance company or agent of an insurance company to knowingly provide false, incomplete or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

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 15 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 15 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.) ☐ 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.

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 **EVER** 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 **EVER** 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? ☐ 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 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 and Terminal Care Rider 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)
	04211-04091-0012				
	9573-001-B4				

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.

Brighthouse FINANCIAL

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

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

Important Notice: Replacement of Life Insurance or Annuities

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**".

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the next page.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy Number	Insured or Annuitant	Replaced (R) or Financing (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

Signatures

I certify that the responses herein are, to the best of my knowledge, accurate:

▶ Applicant's Signature and Printed Name _____ _____

Date _____

▶ Producer's Signature and Printed Name _____ _____

Date _____

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

INITIAL

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

Premiums:	Are they affordable? Could they change? You're older — are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
Policy Values:	New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?
Insurability:	If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.
If You Are Keeping The Old Policy As Well As The New Policy:	How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?
If You Are Surrendering An Annuity Or Interest Sensitive Life Product:	Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?
Other Issues To Consider For All Transactions:	What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

Brighthouse
FINANCIAL

Important Notice: Replacement of Life Insurance or Annuities

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**".

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the next page.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy Number	Insured or Annuitant	Replaced (R) or Financing (F)

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the producer in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

Signatures

I certify that the responses herein are, to the best of my knowledge, accurate:

▶ Applicant's Signature and Printed Name _____ _____

Date _____

▶ Producer's Signature and Printed Name _____ _____

Date _____

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)
INITIAL

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or producer that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your producer to determine whether replacement or financing your purchase makes sense:

Premiums:	Are they affordable? Could they change? You're older — are premiums higher for the proposed new policy? How long will you have to pay premiums on the new policy? On the old policy?
Policy Values:	New policies usually take longer to build cash values and to pay dividends. Acquisition costs for the old policy may have been paid; you will incur costs for the new one. What surrender charges do the policies have? What expense and sales charges will you pay on the new policy? Does the new policy provide more insurance coverage?
Insurability:	If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down. You may need a medical exam for a new policy. Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.
If You Are Keeping The Old Policy As Well As The New Policy:	How are premiums for both policies being paid? How will the premiums on your existing policy be affected? Will a loan be deducted from death benefits? What values from the old policy are being used to pay premiums?
If You Are Surrendering An Annuity Or Interest Sensitive Life Product:	Will you pay surrender charges on your old contract? What are the interest rate guarantees for the new contract? Have you compared the contract charges or other policy expenses?
Other Issues To Consider For All Transactions:	What are the tax consequences of buying the new policy? Is this a tax-free exchange? (See your tax advisor.) Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Will the existing insurer be willing to modify the old policy? How does the quality and financial stability of the new company compare with your existing company?

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

Life Insurance Buyer's Guide

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 Insurer**".

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers. This guide does not endorse any company or policy.

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly.**
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need and for how long and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and study it carefully. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider.

For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

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FINANCIAL

Privacy Notice

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 - Introduction

ⓘ This notice is given to you on behalf of the Company.

Thank you for your application. Now we will review what you told us and may get further information if needed.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured under the coverage you've requested, what we say here also applies to information about him or her.)

SECTION II - 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 requested. 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 help prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. We may also need more information. This may include information about finances, employment, health, hobbies or business conducted with us, with other affiliated companies (our **"affiliates"**) or with other companies.

SECTION III - 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 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 sources may give us reports and may disclose what they know to others. We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

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

This will help us decide if you are eligible for insurance from us and what we should charge for it. For example, anyone who has used nicotine in any form within the last year will not be eligible for our lowest premium rate.

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:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

If we ask an agency for an "investigative" report about you - which means that they will ask others about you - we will ask them to contact you as well. 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 that 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., 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired) or by contacting MIB at www.mib.com.

SECTION IV - How We Protect Information

Because you entrust us with your personal information, 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 also take steps to make our computer databases secure and to safeguard the information we have.

SECTION V - How We Use and Disclose Information

We may use what we know to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. Generally, we will disclose only the information we consider reasonably necessary to disclose. For instance, we may use your information, and disclose it to others, in order to:

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

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

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

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

We may use what we know about you in order to offer you our other products and services. We may also provide information to others outside of the affiliated companies, such as marketing companies, to help us offer our own products and services to you. In addition, we can tell you about our affiliates and the products they offer.

SECTION VI - Opting Out

Affiliate Sharing/Joint Marketing. You may tell us not to share your information with our affiliates for their own marketing purposes or unaffiliated business partners as part of a joint marketing arrangement. Even if you don't "opt out", we will not share your information with unaffiliated companies for their own marketing purposes without a joint marketing arrangement. We will give you an "opt-out" form when we first issue your policy. You can also "opt out" anytime by contacting us at the address below.

Unless you tell us not to share information after receiving an "opt out" notice (see **"How You Can Make an 'Opt Out' Election"** below), we may disclose certain information to our affiliates so that they can offer their products and services directly to you. Even if you do not "opt out," we will not disclose your health information to another company to permit it to market its products to you. We will also not share your information with other unaffiliated companies who may want to market their products directly to you, unless it is in connection with a joint marketing arrangement (as described below). We will not sell or otherwise disclose your information to, for example, a catalog company. Our affiliates include life insurers and a broker-dealer. In the future, we may have affiliates in other businesses. In addition, if we have joint marketing agreements with other unaffiliated companies, we may give them information about you so that we can offer products to you jointly or so they can offer products and services endorsed or sponsored by us to you. But we will not share information for joint marketing if you tell us not to or if the law that applies to you does not allow it.

How You Can Make an "Opt Out" Election: You can tell us not to share your information to let our affiliates market their products directly to you, or not to disclose your information to a third party in connection with a joint marketing arrangement. An "opt-out" election form will be provided to you at the time the policy is issued. You can also "opt-out" anytime by contacting us at the address or website below.

Brighthouse Financial Privacy, P.O. Box 49781, Charlotte, NC 28277, www.brighthousefinancial.com/optout

If you hold a policy or account jointly with someone else, we will accept instructions from either of you, and apply them to the entire policy or account.

SECTION VII - How You Can See And Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you privileged information relating to a claim or lawsuit.) In some circumstances we may disclose what we know about your health through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement if we give this information to anyone outside the Company.

SECTION VIII - You Can Get Other Material From Us

In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.brighthousefinancial.com, or write to the company you applied to, c/o Brighthouse Financial Privacy, P.O. Box 49781, Charlotte, NC 28277.

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.

Understanding Brighthouse Financial Term Offerings

Brighthouse Life Insurance Company
Brighthouse Life Insurance Company of NY

Term Information

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term Insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher unless you are within a level premium period. Ask what the premiums will be if you continue to renew the policy. Also, ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy inforce for a guaranteed period at the same price each year. At the end of that time, you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to convert many term insurance policies to a cash value policy during a conversion period even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Brighthouse Financial offers different term products for varying client needs. Each product and coverage duration is designed to meet specific needs. Through detailed discussion with your financial representative, you can come to the appropriate product and duration selection.

Brighthouse One Year Term (OYT)

OYT offers coverage for one year with no renewal or convertibility options. While coverage is limited to one year, there are certain needs where this may be all the coverage that is necessary. OYT offers affordable protection when you require insurance for the short term. The product is designed to deliver the right amount of protection when it is needed most, or to supplement the policy you already have. The rates for OYT can be found at www.brighthousefinancial.com *(Click on Insurance, Life Insurance, Term Life Insurance)*, or you can request the rates from your agent.

Brighthouse One Year Term (OYT) with Convertible and Renewable Options Rider

OYT with the Convertible and Renewable Options Rider adds renewability for up to five years with increasing premiums. Starting in policy year two and through policy year five, the rider allows conversion to those Brighthouse Financial permanent policies that are regularly offered at time of conversion. This may be a good solution for short-term loans or when a conversion will occur within the first few years.

Guaranteed Level Term (GLT)

GLT offers four different guaranteed level premium periods and is renewable to age 95 with increasing premiums subject to state variations. Convertibility is available to those Brighthouse Financial permanent policies that are regularly offered at the time of conversion for the entire level period up to age 70. For issue ages 65 and older the convertibility period is five years. The distinct level premium periods are 10, 15, 20 and 30 years[1]. Choosing the appropriate length depends on the reason for coverage but with four durations, flexibility in planning is available.

All Brighthouse Financial term products are subject to state availability and variation. All the products are priced independently and quotes are available for any duration upon request. Optional riders exist for potential added

[1]30 year period is not available in New York

flexibility and coverage. For more details, please consult your financial professional.

Like most insurance policies, Brighthouse Financial policies contain charges, limitations, exclusions, termination provisions and terms for keeping them in force. Contact your financial representative for costs and complete details.

Brighthouse One Year Term is issued by Brighthouse Life Insurance Company, Charlotte, NC 28277 on Policy Form 5E-24-12 and in New York only by Brighthouse Life Insurance Company of NY, New York, NY 10166 on Policy Form 1E-24-12-NY-U. Guaranteed Level Term is issued by Brighthouse Life Insurance Company on Policy Form 5E-23-12 and in New York only by Brighthouse Life Insurance Company of NY on Policy Form 1E-23-12-NY (2013). Guarantees are subject to the financial strength and claims-paying ability of the issuing insurance company.

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

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.*				

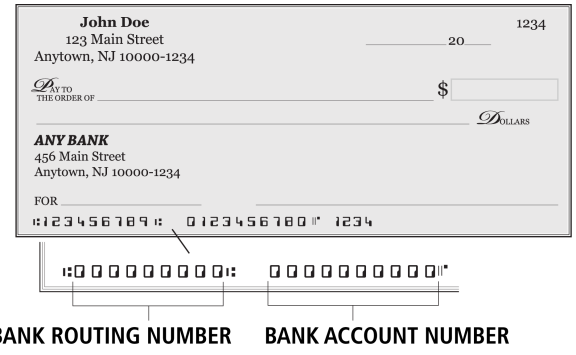
Withdrawal Date is the day of the month we will withdraw from your bank account. If you do not specify a date, monthly withdrawals will occur on the same day of the month as the issue date.

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