

Privacy authorization

Authorization for disclosure of information

Metropolitan Life Insurance Company

Please print clearly and complete all sections.

First name	Middle name	Last name
------------	-------------	-----------

Social Security number

I hereby authorize Metropolitan Life Insurance Company ("*MetLife*") to disclose my protected health information (*including demographics, billing, and policy/plan information*) related to my Long-Term Care Insurance to the person(s) listed below to allow the person(s) to assist in matters related to my insurance coverage. I also authorize MetLife to speak with and to send written correspondence regarding my claim to the person(s) listed below if requested to do so. I understand that this authorization is voluntary.

Name	Relationship	Phone number

I understand that this authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that I may revoke this authorization at any time by notifying MetLife in writing at the address in the enclosed letter, but if I do revoke this authorization, it will not have any effect on any information released before MetLife received the revocation. I understand that refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits.

I understand that the person(s) listed above may re-disclose any information received. Once re-disclosed, the information may not be protected by applicable privacy laws.

Signatures

If signed by your representative, please enclose any related documentation (*e.g. copy of Power of Attorney*)

Sign Here	Signature (<i>you or your representative</i>)	Date (<i>mm/dd/yyyy</i>)
	_____	_____

How to submit this form

Mail:
 MetLife
 Long Term Care Claims
 P.O. Box 14407
 Lexington, KY 40512

Fax:
 866-722-1180

Email:
 longtermcareclaims@metlife.com