MetLife

MEDICAL AUTHORIZATION

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with 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 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last seven years, including medical information, records and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about me relating to mental illness, other than psychotherapy notes; and
- the company to request and obtain consumer reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 990028, Hartford, CT 06199-0028 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

A copy of this form is as valid as the original form.

____________________________ Print Name of Insured

____________________________ Date of Birth

X ____________________________ Signature of Insured

____________________________ Date

P.O. Box 14407
Lexington, KY 40512-9800

Physician Information Form

[This form must be completed by the Insured or their Representative.]

Name of Insured:____

Name of Physician that best knows your medical condition:

____
Specialty:______________________ Date last seen: ___________________

Address:____
City:___________________________ State:_________ Zip code: ________
Phone Number:____

If there is more than one physician that best knows your medical condition, please complete:

Name of Physician:____
Specialty:______________________ Date last seen: ___________________

Address:____
City:___________________________ State:_________ Zip code: ________
Phone Number:____

Name of Physician:____
Specialty:______________________ Date last seen: ___________________

Address:____
City:___________________________ State:_________ Zip code: ________
Phone Number:____

P.O. Box 14407
Lexington, KY 40512-9800

ADDRESS CHANGE REQUEST FORM

Date: ________________

Regarding the MetLife Long-Term Care Policy for:

____

I would like to request to change the mailing address for all correspondence for the insured listed above to the following new address:

(Please print name of insured above and address below)

____

____

____

____

Additionally, the home phone number should be listed as _______________________________

Sincerely,

__________________________________ OR

Signature of Insured

__________________________________ , ________

Signature or POA or Executor

P.O. Box 14407
Lexington, KY 40512-9800

Service Provider Information Form

Name of Insured:____

Name of **CURRENT** Provider:____
Type of provider: □Private Caregiver □RN/LPN/LVN/Physical Therapist □Home Care Agency
□Assisted Living Facility □Nursing Home □Adult Day Care □Other

Address:____
City_________________________ State_______ Zip code____________________

Phone Number:____

Name of **PAST** Provider:____
Type of provider: □Private Caregiver □RN/LPN/LVN/Physical Therapist □Home Care Agency
□Assisted Living Facility □Nursing Home □Adult Day Care □Other

Address:____
City _________________________ State ______ Zip code_____________________

Phone Number:____

Name of **PAST** Provider:____
Type of provider: □Private Caregiver □RN/LPN/LVN/Physical Therapist □Home Care Agency
□Assisted Living Facility □Nursing Home □Adult Day Care □Other

Address:____
City _________________________ State _____ Zip code______________________

Phone Number:____

Name of **FUTURE** Provider:____
Type of provider: □Private Caregiver □RN/LPN/LVN/Physical Therapist □Home Care Agency
□Assisted Living Facility □Nursing Home □Adult Day Care □Other

Address:____
City ________________________ State _______ Zip code_____________________

Phone Number:____

Please Note: Furnishing this information is not a guarantee that the provider will be covered. All providers are subject to certification in accordance with plan provisions. Additional information will be requested of independent or informal caregivers to complete the certification process. The Benefit Authorizing Care Coordinator will need the independent or informal caregivers full name & address, license or certification number (if applicable), the state they obtained their license, and a copy of the caregiver's training certificate, photo identification, and may need their social security number.

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Lexington, KY 40512-9800

Privacy Authorization

Authorization for Disclosure of Information

(PLEASE PRINT CLEARLY AND COMPLETE ALL **BOLDED** SECTIONS)

Name: ____

Social Security Number: ____

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health information (including demographic, billing, claim, and plan information) about my MetLife long-term care insurance to the person(s) listed below to allow that person(s) to assist me in matters related to my insurance coverage. I understand that this authorization is voluntary.

Name	**Relationship**	**Telephone Number** **Please indicate (cell, work, home)**

I understand that this authorization will be valid until such time as I no longer have this long term care insurance, at which time it will expire, or until such time as this authorization is revoked by me, as permitted 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 the individual(s) listed above may re-disclose any information received. Once re-disclosed, the information may not be protected by applicable privacy laws.

_______________________________ ____________________

Signature of the Insured or his/her Personal Representative Date

If signed by Personal Representative of the Insured, please describe the authority under which the Personal Representative is authorized to act and enclose any related documentation (eg. copy of Power of Attorney).

Authority: ____

Print Representative's Name:______________________________

Address: ____

____