U.S. Long-Term Care Claims Operations
MetLife Insurance Company USA

MetLife

Privacy Authorization

Authorization for disclosure of information

Please print clearly and complete all sections.

Name:____

Social Security Number:____

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health information (including demographics, billing, and policy/plan information) about my Long-Term Care Insurance to the person(s) listed below to allow the person(s) to assist me in matters related to my insurance coverage. 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 not 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.

Sign Here — Signature of claimant or authorized representative	Date (mm/dd/yyyy)

If an authorized representative signed above, please print full name of signee:

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