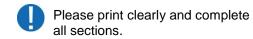


Privacy Authorization



Authorization for disclosure of information

Name:		
Social Security Number:		
including demographics, billing,	and policy/plan information) about ne person(s) to assist me in matter) to disclose my personal health information my Long-Term Care Insurance to the s related to my insurance coverage. I
Name	Relationship	Phone number
aw. I understand that I may reven the enclosed letter, but if I do eleased before MetLife received payment, enrollment, or eligibility	oke this authorization at any time to not revoke this authorization, it will the revocation. I understand that y for benefits. I sted above may re-disclose any in	date on this form or sooner if prescribed by by notifying MetLife in writing at the address not have any effect on any information refusal to sign will not affect treatment, formation received. Once re-disclosed, the
Sign Signature of representati	claimant or authorized ve	Date (mm/dd/yyyy)
If an authorized rep	resentative signed above, ple	ease print full name of signee: