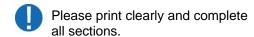
U.S. Long-Term Care Claims Operations P.O. Box 14407 Lexington, KY 40512-9800



Privacy Authorization



Authorization for disclosure of information

hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health informatic 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	Name:Social Security Number:				
understand that this authorization will expire 24 months from the date on this form or sooner if prescribed by aw. I understand that I may revoke this authorization at any time by notifying MetLife in writing at the addres in the enclosed letter, but if I do revoke this authorization, it will not have any effect on any information releas before MetLife received the revocation. I understand that refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits. 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. Signature If signed by your representative, please enclose any related documentation (e.g. copy of Power of Attorney) Sign Signature (you or your representative) Date (mm/dd/yyyy)	hereby authorize Metropolitan Life including demographics, billing, and person(s) listed below to allow the p	Insurance Company ("Metl d policy/plan information) at erson(s) to assist me in ma	Life") to disclose my po bout my Long-Term C	are Insurance to the	
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