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

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 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.

Signature

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

Sign Here	Signature (you or your representative)	Date (mm/dd/yyyy)