

LONG-TERM CARE INSURANCE MEDICAL AUTHORIZATION PACKAGE

IMPORTANT INFORMATION FOR PRODUCERS

- The enclosed HIPAA Authorization form is to be used in all states *EXCEPT* ME, MN, NC, VA and VT. Separate forms for these states will be available at a later time.
- The new HIPAA Authorization form is to be implemented immediately for every Value, Ideal, Premier and Facilities-Only policy sold.
- Please tear out the existing Authorization pages in the application and replace them with this new version.
- Once signed, please mail one copy to MetLife (along with the rest of the GOLD application pages) and leave one copy with the applicant.
- MetLife will notify you when all applications have been updated and use of a separate form is no longer necessary.

Effective May 1, 2003

MetLife[®]
New York, NY 10010

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| MAIL this page to MetLife | Information from: <input checked="" type="checkbox"/> Applicant <input type="checkbox"/> Agent |
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AUTHORIZATION TO RELEASE INFORMATION

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; any insurer; employer; group policyholder, contract holder, or benefit plan administrator 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 three 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; and
- information, records and data about me relating to mental illness, other than psychotherapy notes.

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 937, Westport, CT 06881-0937 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 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 photocopy of this form is as valid as the original form.

✕ _____
Proposed Covered Person

_____/_____/_____
Date of Birth

✕ _____
Signature of Proposed Covered Person

Date

| | |
|---|---|
| LEAVE this page with Applicant | Information from: <input checked="" type="checkbox"/> Applicant <input type="checkbox"/> Agent |
|---|---|

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Proposed Covered Person

_____/_____/_____
Date of Birth

✕ _____
Signature of Proposed Covered Person

Date