MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION

Name of Policyholder: NYSUT Member Benefits Trust	Group Customer # 35370

Source Code (Office Use Only)

NYSUT DB 53162/53163/1003/54127-S
NYSUT PRD 53160/53161/1003/54127
UFT DB 53150/53151/1003/54127-S
UFT PRD 53148/53149/1003/54127
NYSUT DB RET 53156/53157/1003/54127-S
NYSUT PEN RET 53154/53155/1003/54127

YOUR ENROLLMENT INFORMATION

I am the: ☐ NYSUT Member ☐ Spouse/Domestic Partner[1]

Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Phone #	Email Address
NYSUT Member Name (First, Middle, Last)	Member Social Security # / NYSUT ID #	☐ New Enrollment ☐ Change in Enrollment

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Policyholder's Group Insurance Program.

Term Life Insurance

☐ Term Life [1,2,3]

Enter a multiple of $5,000 $_____ up to $1,000,000 (under age 65)
Enter a multiple of $3,000 $_____ up to $30,000 (age 65-69)
Enter a multiple of $2,500 $_____ up to $5,000 (age 80-84), up to $10,000 (age 75-79), up to $20,000 (age 70-74).

☐ Dependent Child Life [3] $25,000

Dependent Information

If you are applying for coverage for your Child(ren), please provide the information requested below:

Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

To be Completed by the Spouse/Domestic Partner, if enrolling for Spouse/Domestic Partner coverage (Owner Information)

NOTE: The Spouse/Domestic Partner of the NYSUT member is considered the owner of Spouse/Domestic Partner coverage. NYSUT Members do not need to complete this section.

Name of Owner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Social Security # of Owner
Address (Street, City, State, Zip Code)		Phone #

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner in whom you have an insurable interest. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to your insurable interest. [2] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor. [3] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF02-1
ADM *applies to residents of Connecticut, North Dakota and Utah)*

SUBMISSION INSTRUCTIONS - A separate form must be completed by each proposed insured.

After completion, sign and date the form on the last page where indicated. Make a copy for your records and return to:
Mercer Consumer, P.O. Box 9186, Des Moines, IA, 50306-9186.
Please note that coverage may not be available in all states. See your plan administrator for additional information.

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your Name _____

Your height _____ feet _____ inches Your weight _____ pounds

	Yes	No
1. Are you now pregnant?	☐	☐
2. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
3. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
4. For residents of all states except CT, please answer the following question: Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? For CT residents, please answer the following question: To the best of your knowledge and belief, have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors?	☐	☐
e. diabetes?	☐	☐
f. asthma, COPD, emphysema or other lung disease?	☐	☐
g. ulcers, stomach, hepatitis or other liver disorder?	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐	☐
i. epilepsy, paralysis, seizures, dizziness or other neurological disorder?	☐	☐
j. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
k. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
l. back, neck, knee, spinal, joint or other musculoskeletal disorder?	☐	☐
m. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
6. Are you currently taking any other prescribed medications?	☐	☐

GEF09-1
HEA
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana; and* **GEF09-1**
HEA *applies to residents of Connecticut, North Dakota and Utah)*

7. In the past 3 years, have you been Hospitalized as defined below (not including well-baby delivery)? Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	☐	☐
8. In the past 2 years, have you used tobacco or nicotine in any form?	☐	☐

If you answered "Yes" to any of the above questions, you must also complete a Statement of Health form. Mercer Consumer will mail you the Statement of Health form upon receipt and review of this enrollment form.

GEF09-1
HEA-SUPP
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
HEA-SUPP *applies to residents of Connecticut, North Dakota and Utah)*

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1
FW
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

BENEFICIARY DESIGNATION

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries including contingent beneficiary information, attach a separate page. Include all beneficiary information, and sign/date the page. If you are adding contingent beneficiaries, please indicate which beneficiaries are to be considered contingent.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. For Members and Associate Members, I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work. For Members, Associate Members or Retired Members, if I am not actively at work, I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities.
3. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Benefits): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

Sign Here

Signature of Owner/Spouse/ Domestic Partner (if applicable)	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1 DEC

(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and **GEF09-1 DEC** *applies to residents of Connecticut, North Dakota and Utah)*

Premium Mode / Payment Option Section:
Select one mode of payment: ☐ Payroll Deduction (Please complete the Payroll Deduction Authorization) ☐ Pension Deduction (Please complete the Pension Deduction Authorization) ☐ Direct Bill Semi-Annually

The MetLife Term Life Insurance Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 7.61% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

▼ Return with application ▼

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust **NYSUT Member Benefits Corporation** **NYSUT Member Benefits CMM Insurance Trust**

MEMBER BENEFITS nysut Working to Benefit You

(Please Print):

Last Name_____ First_____ Middle Initial____

Address_____ NYSUT ID #_____

Home Phone # _____Member's SS #_____

I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.

Signature of Employee_____ **Date**_____

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

Please check your union membership affiliation:

☐ *UFT* ☐ *UUP* ☐ *PSC/CUNY** ☐ *All other NYSUT Locals*

The amount of deductions will be determined by NYSUT Member Benefits based on the programs chosen, and may be adjusted to ensure that premiums are paid in full.

**This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.*

▼ Return with application ▼

NYSUT MEMBER BENEFITS PENSION DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust **NYSUT Member Benefits Corporation** **NYSUT Member Benefits CMM Insurance Trust**

MEMBER BENEFITS nysut Working to Benefit You

(Please Print):

Last Name_____ First_____ Middle Initial_____

Address_____

Phone ( )_____NYSUT ID (seven-digit) #_____

Authorization is for _____Soc. Sec. #_____
(name of plan/insurance)

Please Note: You must be retired for a minimum of six months to be eligible for pension deduction.

Read statements on the reverse side. Signature and date are required.*

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

2K, 9/19, I-106

CHECK ONE BOX ONLY - SIGN AND DATE BELOW

☐ I belong to the Teachers' Retirement System of the **CITY of New York** (TRS) and I hereby request a monthly withholding of deductions from my monthly benefit for the purchase of union-sponsored benefits as permitted by Chapter 248, Laws of 1994.

☐ I belong to the New York City Board of Education Retirement System (BERS).

☐ I belong to the NYSUT Staff Pension Program.

☐ I belong to the New York **STATE** Teachers' Retirement System (NYSTRS), or

☐ I belong to the New York **STATE** Employees' Retirement System (NYSERS) and I hereby request monthly withholding of union deductions from my monthly benefit as permitted by Section 536 of the Education Law and Section 110-C of the Retirement Social Security Law.

NYSERS #:_____

☐ I am a TIAA participant and hereby request a monthly withholding of deductions from my TIAA monthly lifetime annuity income for the purchase of coverages provided through NYSUT Member Benefits' Pension Advantage program. If at any time the total deductions equal or exceed my combined monthly income payments from TIAA, all deductions I have authorized TIAA to take on my behalf will terminate immediately.

I expressly acknowledge and understand that - 1. Deductions will continue until the appropriate Plan Administrator receives written notice from me to the contrary; 2. NYSUT Member Benefits will determine the exact deductions to be withheld monthly and any questions regarding the amount will be directed by me to NYSUT Member Benefits; 3. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity as referenced on the reverse side; 4. For insurance plans, I understand this authorization may be revoked at any time by written notice to the appropriate Plan Administrator; 5. For plans with annual fees, I understand that I must provide written notice to the appropriate Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee. I hereby certify to the NYCTRS, NYSTRS, NYSERS or TIAA that I am a member of NYSUT, an employee organization entitled to receive union deduction payments as provided by law.

***Signature**_____ ***Date**_____

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s)("employee", spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
    medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also 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, your employer for a plan administration purpose 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 relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

Sign Here

Signature of Applicant		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

MetLife

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife
Metropolitan Life Insurance Company, New York, NY

MIB PRE NOTICE

Information regarding your insurability will be treated as confidential. Metropolitan Life Insurance Company ("MetLife") or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of the request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734.

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