Long-Term Care

MetLife

Privacy authorization

Authorization for disclosure of information

Metropolitan Life Insurance Company

Please print clearly and complete all sections.

First name	Middle name	Last name

Social Security number

_____

I hereby authorize Metropolitan Life Insurance Company *("MetLife")* to disclose my protected health information *(including demographics, billing, and policy/plan information)* related to my Long-Term Care Insurance to the person*(s)* listed below to allow the person*(s)* to assist in matters related to my insurance coverage. I also authorize MetLife to speak with and to send written correspondence regarding my claim to the person*(s)* listed below if requested to do so. 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.

Signatures

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)* _____

How to submit this form

Mail:
MetLife
Long Term Care Claims
P.O. Box 14407
Lexington, KY 40512

Fax:
866-722-1180

Email:
longtermcareclaims@metlife.com