The Group Accidental Death and Dismemberment (AD&D) Insurance Plan for Hawaii State Bar Association

Hawaii State Bar Association

ACCIDENTS DO HAPPEN

No one plans to have a serious accident, so when one happens the financial consequences can be devastating. The HSBA AD&D Plan gives you broad accident coverage, 24 hours a day, worldwide. You're covered at home, at work, on vacation, on the road, for practically every activity. See the exclusions section for more information. The plan's benefits are competitive. The rates are competitive. So sign up yourself and your family today. Choose a minimum of $50,000 to a maximum of $500,000 in increments of $25,000. This is worldwide, 24-hour-a-day coverage that pays in addition to any other insurance you may have.

YOU ARE GUARANTEED ACCEPTANCE

All members/employees under age 70 will automatically be accepted into this plan. No physical exam is ever required. Coverage will be effective on the first of the month following receipt of your Enrollment Form and first premium payment. This coverage is available only to residents of the United States and may not be available in all states. Please contact the administrator for details.

FAMILY COVERAGE

Your spouse and dependent children (under age 26) are also guaranteed coverage. Your spouse benefits are 40% of the benefit amount you choose and dependent child(ren)'s benefits are 10% of your benefit. If you are unmarried, each dependent child's coverage will be 15% of your benefit. If you have no children, your spouse's benefits are 50% of your coverage.

Monthly rate per $5,000 for member or employee of member coverage: **$0.25**

Monthly rate per $5,000 for member or employee of member+dependents coverage: **$0.40**

Coverage terminates at age 80. Rates do not increase with age. The rates in this brochure will not be changed unless they are changed for all insureds in your classification. For your convenience, you will be billed annually.

CONVENIENT PAYMENT OPTIONS Four modes of payment are available to suit your budget: Direct Bill Quarterly, Semiannual, and Annual, or Monthly by EFT.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

The following benefits are included as part of your AD&D benefits (See your Certificate for details):

AIR BAG BENEFIT

If the Seat Belt Benefit is payable, MetLife will pay an additional benefit if the insured person was positioned in a seat protected by properly functioning, original, factory-installed airbag system that inflates on impact when the accident occurred. The benefit amount is 5% of the Principal Sum up to $10,000.

SEAT BELT BENEFIT

If an insured person is involved in an automobile accident in which he/she was properly wearing a seatbelt, and dies within 365 days as a result of that accident, the beneficiary can receive the 10% of the Principal Sum up to $25,000.

COMMON CARRIER BENEFIT

If a covered loss occurs as a result of an accident while a passenger on a licensed common carrier (train, bus, etc.), the beneficiary can receive a 100% of Full Amount.

BENEFITS FOR ACCIDENTS

Unless otherwise indicated, MetLife pays only one Full Amount for all losses and benefits while the Group Policy is in effect. The Full Amount is shown on the Schedule of Benefits in your Certificate. For example, if you have loss for which MetLife paid 50% of the Full Amount, MetLife pays no more than 50% of the Full Amount for the next loss.

Loss of:	% of Benefit Paid
Life	100%
Hand	50%
Foot	50%
Arm	75%
Leg	75%
Sight of one eye	50%
Combination of a Hand, Foot, and/or Eye	100%
Thumb & Index Finger on the Same Hand	25%
Speech and Hearing	100%
Speech	50%
Hearing	50%
Paralysis of Both Arms and Both Legs	100%
Paralysis of Both Legs	50%
Paralysis of the Arm & Leg on Either Side of the Body	50%
Paralysis of One Arm or Leg	25%
Brain Damage	100%
Coma	1% monthly up to 60 months

Maximum Amount payable for all Covered Losses sustained in one accident is capped at 100% of the Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed.

Unless otherwise indicated, paralysis must be the result of a spinal cord injury which is due to an accident.

MetLife does not pay an AD&D benefit for any paralysis caused by a stroke. Paralysis must be determined by a doctor to be permanent, complete and irreversible.

Death benefits are paid to your beneficiary. Unless otherwise indicated, all other benefits are paid to you.

TERMINATION

You may maintain your Accidental Death and Dismemberment Insurance coverage until age 80, as long as the Group Policy remains in force, you remain a HSBA member, and pay your premium on time. Coverage for your dependents terminates when your coverage ends, you stop paying premiums, or they are no longer eligible due to change in age, dependency, or marital status, whichever occurs first.

LIMITATIONS

The Accidental Death & Dismemberment loss must occur within 365 days after the date of the accident and be a direct result of bodily injury sustained from that accident, independent of other causes.

EXCLUSIONS

Accidental Death & Dismemberment insurance does not include payment for any loss which in any way results from or is caused by or contributed to by:

- physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
- infection, other than infection occurring in an external accidental wound, or from food poisoning;
- suicide or attempted suicide; (In Missouri, such exclusion only applies while the person is sane);
- intentionally self-inflicted injury;
- service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
- any incident related to: 1) travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; 2) travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight; 3) parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self preservation; 4) travel in an aircraft or device used for testing or experimental purposes; by or for any military authority; or for travel or designed for travel beyond the earth's atmosphere;
- committing or attempting to commit a felony;
- the voluntary intake or use by any means of: 1) any drug, medication or sedative, unless it is: taken or used as prescribed by a Physician, or an ""over the counter"" drug, medication or sedative, taken as directed; 2) alcohol in combination with any drug, medication, or sedative; or 3) poison, gas, or fumes;
- war, whether declared or undeclared; or act of war, insurrection, rebellion, active participation in a riot;
- driving a vehicle or operating another device while intoxicated as defined by the laws of the jurisdiction in which the vehicle or other device was being operated.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your Plan Sponsor and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the booklet certificate.

AD&D coverages are provided under a group insurance policy issued to your plan sponsor by MetLife. AD&D coverage under your plan terminate when your membership ceases, when AD&D contributions cease, or upon termination of the group insurance policy. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent or when a dependent spouse reaches age 80. All insurance and insurance effective dates are subject to final underwriting approval.

Like most insurance policies, insurance policies offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact your plan administrator, AMBA, at 1-866-810-9451 or by email at: customerservice.service@getamba.com for costs and complete details.

Wherever the term spouse appears will read as Domestic Partner throughout the plan summary.

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated, and you will be sent a full refund, no questions asked!

Association Member Benefits Advisors, LLC (AMBA)
P.O. Box 14536
Des Moines, IA 50306

Call: 1-866-810-9451
Email: customerservice.service@getamba.com
Web: www.hsbainsurance.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

Policy number: 261761

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MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:	Sponsoring/Participating Association (if different from Policyholder)	Group Customer #
U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust	**Hawaii State Bar Association**	**261761**

Promo Code # 074030010101	Plan Code # 38526

YOUR ENROLLMENT INFORMATION (To be Completed by the Member/Employee of Member)

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

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.

Accidental Death & Dismemberment (AD&D) Insurance

Member, Employee of Member or Spouse/Domestic Partner [1] of Member:

☐ Voluntary AD&D

First select your option

☐ Member/Employee of Member Only

☐ Member/Employee of Member + Spouse/Domestic Partner [1] + Child(ren)

Then select your level of coverage

Enter a multiple of $25,000 with a maximum of $500,000. $_____

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	
		☐ Male ☐ Female
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.

[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.

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;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated**. Make a copy for your records and return to:
HSBA Group Insurance Program, PO Box 14536, Des Moines, IA 50306
Email: customerservice.service@getamba.com / Phone: 1-866-810-9451

Hawaii State Bar Association (VADD)
EF-SOH-ST143M-NW (06/25)

FRAUD WARNINGS

Before signing this Statement of Health 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 Insurance): 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.

BENEFICIARY DESIGNATION FOR MEMBER/EMPLOYEE OF MEMBER INSURANCE

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 also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Member/Employee of Member.
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(S)

Member/Employee of Member

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. **Member:** I declare that I am able to perform the normal activities required to be covered under the plan on the date I am enrolling. I declare that on the date of insurance I am not confined at home under a physician's care, receiving or applying to receive disability benefits from any source, or Hospitalized. I understand that if I do not meet these requirements on such date, my insurance will take effect on the date I am no longer confined, receiving or applying to received disability benefits, or Hospitalized. **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.

   Employee of Member: I declare that I am actively at work on the date I am enrolling and that I was actively at work performing all of the usual and customary duties during my regular work schedule preceding my date of enrollment. 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.
3. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member/Employee of Member	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;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

Spouse/Domestic Partner of Member

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **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.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Spouse/Domestic Partner of Member	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;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

Hawaii State Bar Association (VADD)
EF-SOH-ST143M-NW (06/25)

Payment Information

The first paper bill and EFT form will be sent to you once your coverage is approved. You will then have the option to sign up for EFT to maintain your coverage going forward.

I am selecting the following frequency of payment (check one): ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

MetLife

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

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.

SECTION 1: 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, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice, "you" refers to these individuals.

SECTION 2: 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.

SECTION 3: 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 insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: 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, LLC ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a 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. You may do so by writing to MIB LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: 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

SECTION 6: 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

SECTION 7: 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.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. 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.

SECTION 9: 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. A detailed notice shall be furnished to you upon request. 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 the MetLife companies listed at the top of the first page.