Group 20-Year Level Term Life Insurance Plan Summary

Hawaii State Bar Association

FOR HSBA MEMBERS, MEMBER SPOUSES, MEMBER DEPENDENTS AND EMPLOYEES OF MEMBERS

You certainly understand the importance of having sufficient life insurance. Now you have an opportunity to make sure that you have the amount of coverage needed. Your loved ones will appreciate the peace of mind this Plan provides, with benefits up to $1,000,000 that will let them go on with their lives with fewer financial concerns.

About This Plan

You and your spouse may select from $50,000 up to $1,000,000 in 20-Year Life insurance coverage (in $5,000 increments). The spouse coverage may not exceed 100% of member's coverage. Coverage continues as long as long as you remain an active member of the Hawaii State Bar Association, pay your premium when due, and the Group Policy remains in force.

Eligibility

All HSBA members under age 55 may apply for coverage for themselves, their spouse partner under age 65 and all unmarried dependent children ages 14 days through 26 years.

If both member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

Child(ren) premiums: $2.00 monthly covers all dependent children for $10,000 each.

Employee Coverage Available

Employees of HSBA members under age 55 may also apply for 20-Year Life insurance through MetLife. Employees may select from $50,000 to $1,000,000 of coverage (in increments of $25,000). In order for an employee to be covered, the employee must be eligible for the insurance, be actively at work, and be able to provide MetLife with acceptable proof of good health.

Accelerated Life Benefit[1]

An individual can receive up to 80% of their term life insurance proceeds to a maximum of $500,000 for members, member spouses and employees of members when the terminally ill person has less than 24 months to live. This can go a long way toward helping an insured's family meet medical and other related expenses at this difficult time.

Waiver of Life Insurance Premium Disability Benefit

If you or your insured employee become disabled prior to age 60 and remain disabled for six (6) continuous months, the insurance company will waive your or their premium payments, as applicable, for as long as you or they continue to meet the definition of disability, or until the age of 75. If you or they recover and no longer meet the definition of disability, premium must again be paid when due.

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!

Is a medical exam required?

You must complete a standard application. When you apply, simply answer the health questions. Even if you have a health condition, you may still qualify. Depending on the amount applied for, a paramedical exam and blood test may be required, which will be scheduled at your convenience and at no cost to you.

Will this level term plan pay in addition to other coverage?

Yes. The level term plan pays in addition to any other insurance coverage you have. The plan also stays with you until your coverage ends. If also electing coverage under the HSBA level term life insurance plans, a combined maximum benefit amount of $1,000,000 between the level term life insurance plans and the annual renewable term life insurance will apply.

What are my options when my 20-year term comes to an end?

Premiums are designed to remain level for the first 20 years of coverage. At the end of the 20-year period, if you still meet the requirements of eligibility, you may apply for re-entry. A written application and proof of good health satisfactory to MetLife is required.

Would I have the ability to continue coverage, should my plan end?

Yes, in many instances. If your insurance ends for a reason other than non-payment of your premiums, you may be able to convert your coverage into an individual life insurance policy from Metropolitan Life Insurance Company or an affiliate without providing evidence of insurability. Please see the certificate of insurance for details, including eligibility for conversion and amount of coverage that may be converted.

Are there any exclusions to my coverage?

Yes. Benefits will not be paid if the death of the member, member's dependent or member's employee occurs from suicide within two years of the effective date of their insurance or the date of any increase in insurance. The Accelerated Life benefits are subject to additional exclusions. Please see your certificate for details.

Valuable built-in features at no additional cost to you

Will Preparation Services[2]

Offers the insured person and their spouse unlimited face-to-face or telephone meetings with an attorney, from MetLife Legal Plans' network of over 18,500 participating attorneys, to prepare or update a will, living will, and Power of Attorney.

Estate Resolution Services[2]

Estate representatives and beneficiaries may receive unlimited face-to-face legal assistance with probating an insured person's and their spouse's estate. Beneficiaries can also consult an attorney, from MetLife Legal Plans' network of over 18,500 participating attorneys, for general questions about the probate process.

Grief Counseling[3]

Provides an insured and their dependents up to five private counseling sessions with a professional grief counselor — per event — to help cope with a loss, no matter the circumstances, whether it's a death, an illness or divorce. Sessions may also be held over the phone.

Funeral Planning Assistance[3]

Services designed to simplify the funeral planning process for an insured's loved ones and beneficiaries to assist them with organizing an event that will honor a loved one's life, from a self-paced funeral planning guide to services such as locating funeral homes, florists and local support groups.

HSBA 20-YEAR GROUP LEVEL TERM MONTHLY RATES PER $5,000

Member/Spouse/Employee of Member

Volume Band: $200,000 - $475,000

	Male			Female		
Issue Age	Tobacco	Non-Tobacco Select	Non-Tobacco Preferred	Tobacco	Non-Tobacco Select	Non-Tobacco Preferred
18-26	0.80	0.45	0.35	0.55	0.30	0.25
27	0.85	0.45	0.35	0.60	0.35	0.25
28	0.90	0.45	0.35	0.65	0.35	0.25
29	0.95	0.50	0.35	0.70	0.35	0.30
30	1.00	0.50	0.40	0.80	0.40	0.30
31	1.10	0.55	0.40	0.85	0.40	0.30
32	1.15	0.55	0.40	0.90	0.45	0.30
33	1.25	0.60	0.45	1.00	0.45	0.35
34	1.40	0.60	0.45	1.10	0.50	0.35
35	1.50	0.65	0.45	1.15	0.50	0.35
36	1.65	0.70	0.50	1.25	0.55	0.40
37	1.80	0.75	0.55	1.35	0.60	0.40
38	1.95	0.80	0.60	1.45	0.65	0.45
39	2.15	0.85	0.60	1.60	0.70	0.50
40	2.30	0.95	0.65	1.70	0.75	0.50
41	2.55	1.00	0.70	1.85	0.80	0.55
42	2.75	1.10	0.75	1.95	0.85	0.60
43	3.00	1.20	0.85	2.10	0.90	0.60
44	3.25	1.30	0.90	2.25	0.95	0.65
45	3.60	1.45	1.00	2.45	1.00	0.70
46	3.90	1.60	1.10	2.65	1.10	0.75
47	4.20	1.75	1.20	2.80	1.20	0.80
48	4.55	1.90	1.30	3.00	1.25	0.85
49	4.90	2.10	1.45	3.20	1.35	0.95
50	5.35	2.30	1.55	3.40	1.50	1.00

Rates shown are as of February 1, 2025.

Premiums are based on your age at date of issue and will not increase due to your age or health status. Coverage will not be reduced during your level term period. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class[4]. Coverage will become effective the 1st day of the month after the application is approved by MetLife. To obtain a rate quote for other ages, benefit amounts, or for information on the 20-year Level Term Life Plan, call toll-free 1-866-810-9451.

The classes of rates are “Standard” “Select” and “Preferred”. Only non-tobacco users may qualify for the “Select” and “Preferred” rates. (Note: Tobacco users may only qualify for the “Standard” rates. A tobacco user is anyone who has used tobacco in any form in the past 2 years.) Upon approval of your Application by the insurer, you will be notified of the rate classification for each approved person. Acceptance into this Plan is subject to medical evidence of insurability as determined by MetLife. Depending on your age, amount of coverage you applied for and your answers on the Application, a medical examination, medical test (s) or other evidence of good health may be required. Any exams/tests requested by the insurer will be conducted at your convenience at no expense to you. **NOTE:** If you are between the ages of 18 to under 55 you may be eligible to apply for the HSBA Group 20-Year Level Term Life Insurance. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the HSBA Insurance Administrator at 1-866-810-9451.

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.

HSBA 20-YEAR GROUP LEVEL TERM MONTHLY RATES PER $5,000

Member/Spouse/Employee of Member

Volume Band: $500,000 - $1,000,000

	Male			Female		
Issue Age	Tobacco	Non-Tobacco Select	Non-Tobacco Preferred	Tobacco	Non-Tobacco Select	Non-Tobacco Preferred
18-26	0.75	0.40	0.30	0.55	0.30	0.20
27	0.80	0.40	0.30	0.60	0.30	0.20
28	0.85	0.45	0.30	0.65	0.30	0.20
29	0.90	0.45	0.30	0.70	0.35	0.25
30	1.00	0.45	0.35	0.75	0.35	0.25
31	1.05	0.50	0.35	0.80	0.35	0.25
32	1.15	0.50	0.35	0.90	0.40	0.25
33	1.25	0.55	0.35	0.95	0.40	0.30
34	1.40	0.55	0.40	1.05	0.45	0.30
35	1.50	0.60	0.40	1.15	0.50	0.30
36	1.65	0.65	0.45	1.25	0.50	0.35
37	1.80	0.70	0.45	1.35	0.55	0.40
38	1.95	0.75	0.50	1.45	0.60	0.40
39	2.15	0.80	0.55	1.60	0.65	0.45
40	2.35	0.85	0.55	1.70	0.70	0.50
41	2.55	0.90	0.60	1.85	0.75	0.50
42	2.80	1.00	0.70	2.00	0.80	0.55
43	3.05	1.10	0.75	2.15	0.85	0.55
44	3.35	1.25	0.80	2.30	0.90	0.60
45	3.65	1.40	0.90	2.45	1.00	0.65
46	3.95	1.50	1.00	2.65	1.05	0.70
47	4.25	1.60	1.10	2.80	1.15	0.75
48	4.60	1.80	1.20	3.00	1.25	0.80
49	5.00	1.95	1.30	3.20	1.35	0.90
50	5.45	2.15	1.45	3.45	1.45	0.95

Rates shown are as of February 1, 2025.

Premiums are based on your age at date of issue and will not increase due to your age or health status. Coverage will not be reduced during your level term period. Premiums will only be increased if premiums are increased for all insureds in the same age and rate class[4]. Coverage will become effective the 1st day of the month after the application is approved by MetLife. To obtain a rate quote for other ages, benefit amounts, or for information on the 20-year Level Term Life Plan, call toll-free 1-866-810-9451.

The classes of rates are “Standard” “Select” and “Preferred”. Only non-tobacco users may qualify for the “Select” and “Preferred” rates. (Note: Tobacco users may only qualify for the “Standard” rates. A tobacco user is anyone who has used tobacco in any form in the past 2 years.) Upon approval of your Application by the insurer, you will be notified of the rate classification for each approved person. Acceptance into this Plan is subject to medical evidence of insurability as determined by MetLife. Depending on your age, amount of coverage you applied for and your answers on the Application, a medical examination, medical test (s) or other evidence of good health may be required. Any exams/tests requested by the insurer will be conducted at your convenience at no expense to you. **NOTE:** If you are between the ages of 18 to under 55 you may be eligible to apply for the HSBA Group 20-Year Level Term Life Insurance. For more information including eligibility, rates, benefit provisions, exclusions, limitations and termination provisions, please contact the HSBA Insurance Administrator at 1-866-810-9451.

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.

1. The Accelerated Benefits Option is subject to state regulation and is intended to qualify for favorable federal income tax treatment, in which case the benefits will not be subject to federal income taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of accelerated benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of accelerated benefits will have on public assistance eligibility for you, your spouse or your family.
2. Will Preparation and MetLife Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, Rhode Island. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.
3. Grief Counseling and Funeral Assistance services are provided through an agreement with TELUS Health. TELUS Health is not an affiliate of MetLife, and the services TELUS Health provides are separate and apart from the insurance provided by MetLife. TELUS Health has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms. In some cases a medical exam may be required (at no cost to you). When you apply, simply answer the health questions. Depending on the amount applied for, a paramedical exam and blood test may be required, which will be scheduled at your convenience. Even if you have a health condition, you still may qualify.
4. The group contract provides MetLife with the right to adjust the rates and/or the rate guarantee period should overall group participation change significantly.

All applications for coverage are subject to review and approval by MetLife. If you choose to apply for increased coverage, the increase may be subject to underwriting. MetLife will review your information and evaluate your request for coverage based upon your answers to the health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage. Coverage will be effective in accordance with the applicable policy and certificate after approval by MetLife.

Coverage may not be available in all states. For more information, please contact your plan administrator, AMBA, at 1-866-810-9451 or by email at: customerservice.service@getamba.com.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of coverage. All coverage is subject to the terms of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern.

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

All insurance and insurance effective dates are subject to final underwriting approval.

MetLife

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

Do not send any money until Metropolitan Life Insurance Company has approved your Application and notifies you of the premium contribution due, based on the information you have provided.

Policy number: 261761

L1124044903[exp1126][All States][DC,GU,MP,PR,VI]

AMBA

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

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM
10/20 Year Level Term

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder:	Sponsoring/Participating Association (if different from Policyholder)	Group Customer #	Report #
U.S. Bank National Association, as Trustees of the MetLife Illinois Multiple Association Benefits Trust	**Hawaii State Bar Association**	**261761**	**262112**

Promo Code # 074030010101 | Plan Code # 38512

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

Name (First, Middle, Last)		Social Security # – –
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)

By applying for this insurance coverage, do you intend to replace, discontinue or change any existing life insurance or annuity contracts currently held by you? ☐ Yes ☐ No

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.

► You must complete the Health Information section of this form and the enclosed Authorization form for all amounts you are requesting.

Term Life Insurance

Member:

☐ Supplemental Term Life[1]

Enter a multiple of $5,000, with a minimum of $50,000, up to a maximum of $1,000,000 $_____

Select Your Term: ☐ 10-Year Level Term ☐ 20-Year Level Term

Employee of Member:

☐ Supplemental Term Life[1]

Enter a multiple of $5,000, with a minimum of $50,000, up to a maximum of $250,000 $_____

Select Your Term: ☐ 10-Year Level Term ☐ 20-Year Level Term

Spouse/Domestic Partner [2] of Member:

☐ Dependent Spouse/Domestic Partner[2] Life [1,3]

Enter a multiple of $5,000, with a minimum of $50,000, up to a maximum of $1,000,000 $_____

Select Your Term: ☐ 10-Year Level Term ☐ 20-Year Level Term

Member or Spouse/Domestic Partner [2] of Member:

☐ Dependent Child Life[3]

☐ $5,000 ☐ $10,000

[1] 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.

[2] 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.

[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;*
GEF02-1
ADM *applies to residents of Connecticut, 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

Accidental Death & Dismemberment (AD&D) Insurance

Member, Employee of Member or Spouse/Domestic Partner [2] of Member:

☐ Voluntary AD&D

First select your option

☐ Member/Employee of Member Only

☐ Member/Employee of Member + Spouse/Domestic Partner [2] + 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.

[2] 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 Connecticut, North Dakota and Utah)*

HEALTH INFORMATION

SECTION 1

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. For questions 5 through 11u, for "yes" answers, please provide full details in Section 2.

1. Member/Employee of Member height ____ feet ____ inches
   Member/Employee of Member weight ____ pounds
   Spouse/Domestic Partner height ____ feet ____ inches
   Spouse/Domestic Partner weight ____ pounds

	Member/EE of Member	Spouse/Domestic Partner
2. Are you now on a diet prescribed by a physician or other health care provider?	☐ Yes ☐ No	☐ Yes ☐ No
Member/EE of Member: Indicate type _____		
Spouse/Domestic Partner Indicate type _____		
3. Are you now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
Member/EE of Member: If "yes," what is your due date (month/day/year)? _____		
Physician's name _____ Telephone: (____) ____ – ____		
Spouse/Domestic Partner:		
If "yes," what is your due date (month/day/year)? _____		
Physician's name _____ Telephone: (____) ____ – ____		
4. Are you now, or have you in the past 2 years, used tobacco in any form?	☐ Yes ☐ No	☐ Yes ☐ No

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;*
GEF09-1
HEA *applies to residents of Connecticut, North Dakota and Utah)*

	Member/EE of Member	Spouse/Domestic Partner
5. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) Member/EE of Member: _____ Spouse/Domestic Partner: _____	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? Member/EE of Member: ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified ☐ issued other than as applied for? Indicate reason _____ Spouse/Domestic Partner: ☐ declined ☐ postponed ☐ withdrawn ☐ rated ☐ modified ☐ issued other than as applied for? Indicate reason _____	☐ Yes ☐ No	☐ Yes ☐ No
7. Are you now receiving or applying for any disability benefits, including workers' compensation? Member/EE of Member: If "yes" provide details _____ Spouse/Domestic Partner: If "yes" provide details _____	☐ Yes ☐ No	☐ Yes ☐ No
8. 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?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐ Yes ☐ No	☐ Yes ☐ No
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.		
10. **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), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? **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), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
b. stroke or circulatory disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
c. high blood pressure?	☐ Yes ☐ No	☐ Yes ☐ No
d. cancer, Hodgkins disease, lymphoma or tumors? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
e. anemia, leukemia or other blood disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
f. diabetes? Member/EE of Member: Your age at diagnosis?: _____ ☐ Check if insulin treated Spouse/Domestic Partner: Your age at diagnosis? _____ ☐ Check if insulin treated	☐ Yes ☐ No	☐ Yes ☐ No
g. asthma, COPD, emphysema or other lung disease? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
h. ulcers, stomach, hepatitis or other liver disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No

		Member/EE of Member	Spouse/Domestic Partner
i.	colitis, Crohn's, diverticulitis or other intestinal disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
j.	memory loss? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
k.	epilepsy, paralysis, seizures, dizziness or other neurological disorder? Member/EE of Member: Specify date of last seizure (month/year) _____ Indicate type _____ Spouse/Domestic Partner: Specify date of last seizure (month/year) _____ Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
l.	Epstein-Barr, chronic fatigue syndrome or fibromyalgia? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
m.	multiple sclerosis, ALS or muscular dystrophy? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
n.	lupus, scleroderma, auto immune disease or connective tissue disorder?	☐ Yes ☐ No	☐ Yes ☐ No
o.	arthritis? Member/EE of Member: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____ Spouse/Domestic Partner: ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐ Yes ☐ No	☐ Yes ☐ No
p.	back, neck, knee, spinal, joint or other musculoskeletal disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
q.	carpal tunnel syndrome?	☐ Yes ☐ No	☐ Yes ☐ No
r.	kidney, urinary tract or prostate disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
s.	thyroid or other gland disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
t.	mental, anxiety, depression, attempted suicide or nervous disorder? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No
u.	sleep apnea? Member/EE of Member: Indicate type _____ Spouse/Domestic Partner Indicate type _____	☐ Yes ☐ No	☐ Yes ☐ No

After completing the Personal Physician and Prescription Information, please provide full details in Section 2 for "yes" answers to questions 5 through 11u.

MEMBER/EMPLOYEE OF MEMBER SECTION

Personal Physician Information

Personal Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit (MM/YYYY): ____/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

☐ Check here if you are attaching another sheet for any additional medications.

MEMBER/EMPLOYEE OF MEMBER SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your Date of Birth ____/____/____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit: _____ Reason for visit: _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit: _____ Reason for visit: _____

SPOUSE/DOMESTIC PARTNER SECTION

Personal Physician Information

Personal Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit (MM/YYYY): ____/____ Reason for visit: _____

Prescription Information

Are you currently taking any prescribed medications? ☐ Yes ☐ No If yes, list the medications.

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

Medication: _____ Condition/Diagnosis: _____

Prescribing Physician's Name: _____ Telephone: (____) ____–____

☐ Check here if you are attaching another sheet for any additional medications.

SPOUSE/DOMESTIC PARTNER SECTION 2

Please provide full details below for each "Yes" answer to questions 5 through 11u in Section 1. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information. ☐ Check here if you are attaching another sheet.

Your Date of Birth ____/____/____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit: _____ Reason for visit: _____

Question Number	Condition/Diagnosis/Type	Please list any medication prescribed that you did not already identify in the Prescription Information above.
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment

Treating Health Professional

Physician's Name: _____ Telephone: (____) ____–____

Approximate last visit: _____ Reason for visit: _____

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.

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;*
GEF09-1
FW *applies to residents of Connecticut, North Dakota and Utah)*

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, including any health 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 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.

   For Employee of Member: I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of application. 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 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.
4. 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. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. 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 Connecticut, North Dakota and Utah)*

Spouse/Domestic Partner

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health 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. I have read the applicable Fraud Warning(s) provided in this enrollment form.

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

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) ("member", spouse, and/or 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, LLC ("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;
  - 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, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- 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, 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 Member/Employee of Member		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Sign Here

Signature of Spouse/Domestic Partner		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Hawaii State Bar Association (Combo) - 261761
AUTH-ST110M-NW (06-24)

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, LLC. which operates an information exchange on behalf of insurance companies that are members of MIB Group Inc. 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 or go to its website at www.mib.com to request disclosure online. 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.

MetLife, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.