

MEDICAL AUTHORIZATION

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefit plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical file for the last seven years, including medical information, records and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
- information, records and data about me relating to mental illness, other than psychotherapy notes; and
- the company to request and obtain consumer reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 990028, Hartford, CT 06199-0028 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

A copy of this form is as valid as the original form.

Print Name of Insured

Date of Birth

X _____
Signature of Insured

Date

P.O. Box 14407
Lexington, KY 40512-9800



Physician Information Form

[This form must be completed by the Insured or their Representative.]

Name of Insured: _____

Name of Physician that best knows your medical condition:

Specialty: _____ Date last seen: _____

Address: _____ ✓

City: _____ State: _____ Zip code: _____

Phone Number: _____

If there is more than one physician that best knows your medical condition, please complete:

Name of Physician: _____

Specialty: _____ Date last seen: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

Name of Physician: _____

Specialty: _____ Date last seen: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____

P.O. Box 14407
Lexington, KY 40512-9800



ADDRESS CHANGE REQUEST FORM

Date: _____

Regarding the MetLife Long-Term Care Policy for:

I would like to request to change the mailing address for all correspondence for the insured listed above to the following new address:

(Please print name of insured above and address below)

Additionally, the home phone number should be listed as _____

Sincerely,

OR

Signature of Insured

_____ , _____

Signature or POA or Executor

P.O. Box 14407
Lexington, KY 40512-9800



Service Provider Information Form

Name of Insured: _____

Name of **CURRENT** Provider: _____

Type of provider: Private Caregiver RN/LPN/LVN/Physical Therapist Home Care Agency
 Assisted Living Facility Nursing Home Adult Day Care Other

Address: _____

City _____ State _____ Zip code _____

Phone Number: _____

Name of **PAST** Provider: _____

Type of provider: Private Caregiver RN/LPN/LVN/Physical Therapist Home Care Agency
 Assisted Living Facility Nursing Home Adult Day Care Other

Address: _____

City _____ State _____ Zip code _____

Phone Number: _____

Name of **PAST** Provider: _____

Type of provider: Private Caregiver RN/LPN/LVN/Physical Therapist Home Care Agency
 Assisted Living Facility Nursing Home Adult Day Care Other

Address: _____

City _____ State _____ Zip code _____

Phone Number: _____

Name of **FUTURE** Provider: CareWorks Health Services

Type of provider: Private Caregiver RN/LPN/LVN/Physical Therapist Home Care Agency
 Assisted Living Facility Nursing Home Adult Day Care Other

Address: 18682 Beach Blvd. #225

City Huntington Beach State CA Zip code 92648

Phone Number: 949-859-4700

Please Note: Furnishing this information is not a guarantee that the provider will be covered. All providers are subject to certification in accordance with plan provisions. Additional information will be requested of independent or informal caregivers to complete the certification process. The Benefit Authorizing Care Coordinator will need the independent or informal caregivers full name & address, license or certification number (if applicable), the state they obtained their license, and a copy of the caregiver's training certificate, photo identification, and may need their social security number.

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Privacy Authorization

Authorization for Disclosure of Information (PLEASE PRINT CLEARLY AND COMPLETE ALL **BOLDED** SECTIONS)

Name: _____

Social Security Number: _____

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health information (including demographic, billing, claim, and plan information) about my MetLife long-term care insurance to the person(s) listed below to allow that person(s) to assist me in matters related to my insurance coverage. I understand that this authorization is voluntary.

Name	Relationship	Telephone Number <small>Please indicate (cell, work, home)</small>
Anh Dang- CareWorks	Home Care Provider	work- 949-859-4700
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that this authorization will be valid until such time as I no longer have this long term care insurance, at which time it will expire, or until such time as this authorization is revoked by me, as permitted 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 the individual(s) listed above may re-disclose any information received. Once re-disclosed, the information may not be protected by applicable privacy laws.

Signature of the Insured or his/her
Personal Representative

Date

If signed by Personal Representative of the Insured, please describe the authority under which the Personal Representative is authorized to act and enclose any related documentation (eg. copy of Power of Attorney).

Authority: _____

Print Representative's Name: _____

Address: _____
