



American Federation of Teachers Disability Income Insurance Rates

	Option 1	Option 2	Option 3		Option 4 ¹	Option 5 ¹
Elimination Period:	14 Days	60 Days	90 Days	Elimination Period:	60 Days	90 Days
Benefit Duration:	2 Years	5 Years	5 Years	Benefit Duration:	To age 65	To age 65
Age ²	Monthly rates per \$100 of benefit	Monthly rates per \$100 of benefit	Monthly rates per \$100 of benefit	Age ²	Monthly rates per \$100 of benefit	Monthly rates per \$100 of benefit
< 35	\$2.11	\$0.81	\$0.74	< 35	\$1.38	\$1.14
35-39	\$1.77	\$1.03	\$0.93	35-39	\$1.86	\$1.53
40-44	\$1.91	\$1.41	\$1.27	40-44	\$2.58	\$2.13
45-49	\$2.33	\$1.91	\$1.72	45-49	\$3.27	\$2.69
50-54	\$3.11	\$2.70	\$2.43	50-54	\$4.04	\$3.30
55-59	\$4.46	\$4.11	\$3.71	55-59	\$4.88	\$4.00
60 >	\$7.25	\$5.57	\$5.02	60-64	\$6.14	\$5.06
				65 >	\$5.65	\$4.41

¹ Benefit duration to social security normal retirement age.

² Age is the participant's age as of last birthday.

How to Calculate Your PREMIUM:

(Cost from your age bracket) X (# of Units) = Monthly Premium

Example: Age 37
Amount of coverage desired: \$2,000 per month
\$1.77 x 20 (units) = \$35.40 per month

How to Calculate Your PAYMENT OPTIONS:

Example: **Quarterly payments:** (monthly premium) X 3 = Quarterly payment
\$35.40 x 3 = \$106.20

Semi-annual payments: (monthly premium) X 6 = Semi-annual payment
\$35.40 x 6 = \$212.40

Annual payments: (monthly premium) X 12 = Annual payment
\$35.40 x 12 = \$424.80



ENROLLMENT FORM FOR AMERICAN FEDERATION OF TEACHERS BENEFIT TRUST
SECTION TO BE COMPLETED BY AFT MEMBER

American Federation of Teachers Benefit Trust			Group Report No.	Sub Division	Branch N/A	
Member's Occupation:		Member's Work Schedule (Minimum 20 Hours Per Week). Scheduled Work Hours: _____				
Reason for Enrollment: <input type="checkbox"/> New Member/First Time Eligible <input type="checkbox"/> Late Enrollee* <input type="checkbox"/> Change in Coverage Amount Requested* <input type="checkbox"/> Family Status Change* (not applicable to new enrollments) Date (Mo./Day/Yr.) _____						
*(Statement of Health Required)						
Member Name (print) First		Middle	Last	Social Security No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address Street		City		State	Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
E-mail Address			Phone No. (include area code)		Member's Basic Annual Earnings (BAE) \$	
COVERAGE REQUEST DATA:						
I have received and read a copy of AFT's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.						
I request the following coverage:						
Member Coverage						
Long Term Disability - Select an option:						
<input type="checkbox"/> Option One - Two year benefit duration						
<input type="checkbox"/> Option Two - Five year benefit duration (60 day elimination period)						
<input type="checkbox"/> Option Three - Five year benefit duration (90 day elimination period)						
<input type="checkbox"/> Option Four - Benefit duration to your social security normal retirement age (60 day elimination period)						
<input type="checkbox"/> Option Five - Benefit duration to your social security normal retirement age (90 day elimination period)						
Monthly Benefit Amount Requested: \$ _____						
Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?				Member		
				<input type="checkbox"/> Yes <input type="checkbox"/> No		
If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."						
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 treatments wherever performed: chemotherapy, radiation therapy, or dialysis.						

Please Retain A Copy Of The Fully-Completed Form For Your Records and Return The Original To
USI Affinity, P.O. Box 505, Matawan, NJ 07747. For questions call 888-423-8700

Medical Information

Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the person for whom insurance is requested.

- | | Member |
|---|--|
| 1. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | |
| a. chest pain or heart trouble? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. high blood pressure, stroke or circulatory disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. cancer or tumors? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. anemia, leukemia or other blood disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. 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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Are you now receiving or applying for any disability benefits including workers' compensation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered "Yes" to any of the above questions, you must also complete and attach a Statement of Health form.

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DECLARATION SECTION

The person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The member declares that he or she is actively at work on the date of this enrollment form.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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, 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.

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

Massachusetts: 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas, Oregon, and Vermont: 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia 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 include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 may be a crime and may subject such person to criminal and civil penalties.

Signature(s): The member must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.



_____ Member Signature

_____ Print Name

_____ Date Signed (Mo./Day/Yr.)

Metropolitan Life Insurance Company Statement of Health Form Instructions

Based on your enrollment, a Statement of Health is required to complete your request for group insurance coverage. Below are instructions for Completing the Statement of Health Form

A separate Statement of Health form is required for each Proposed Insured / Applicant requesting insurance.

PLEASE USE THE CHECKBOXES TO ENSURE PROPER COMPLETION OF THE FORM.

Information to be Completed by USI Affinity

- Enter USI Affinity Name
- Enter Customer Number
- Enter SOH Reporting Location (if applicable)
- Enter USI Affinity Address
- Select type of Insurance
 - If Life Insurance, enter the additional amount of insurance
- Enter Enrollment Year or year of requested increase (usually current year) for reporting purposes only

Information to be Completed by Proposed Insured / Applicant

The Proposed Insured / Applicant must complete all information located in the boxes at the top:

- Enter Member Name and Social Security Number**
- Enter Relationship of Proposed Insured / Applicant to Member
- Enter Proposed Insured / Applicant's
 - Name
 - Sex
 - Date of Birth
 - Mailing Address
 - Business Telephone Number
 - Home Telephone Number
 - Email Address
 - State of Birth
 - Country of Birth

****NOTE: The Member's Name and Social Security Number must appear on the form.**

Medical Information — must be completed.

- Complete Question 1.
- Check "Yes" or "No" for Questions 2–6 (all parts).
- Complete Question 7.
- Complete the details section if ANY of the questions 2 through 6 were answered "Yes."

Signatures

- The Member must always sign and date the **Statement of Health** form.
- The Proposed Insured / Applicant (if over the age of 18) must sign and date the **Statement of Health and Authorization** forms. If the Proposed Insured / Applicant is under the age of 18, his/her personal representative must sign and date the Authorization.

Upon completion, detach the Consumer Privacy Notice and retain for your records. Make a copy of the completed form for your records and FAX or MAIL the completed 3-pages to the Statement of Health (SOH) Unit at MetLife.

Metropolitan Life Insurance Company
Statement of Health Unit
P.O. Box 14069
Lexington, KY 40512-4069
FAX: 1-859-225-7909

Note: Additional medical information may be required after initial review of completed forms. This information may be in the form of a physical examination, paramedical exam, or Attending Physician Report, in which correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned for completion. For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email ei@metlife.com.

STATEMENT OF HEALTH FORM

To be Completed by the USI Affinity

-PLEASE PRINT CLEARLY-

Union: American Federation of Teachers		Customer Number 119160	Reporting Location Number	
Address		City	State	Zip Code
Insurance Requested (To be completed for each Proposed Insured / Applicant) <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental / Optional Life <input type="checkbox"/> Group Universal Life <input type="checkbox"/> Group Variable Universal Life <input type="checkbox"/> Dependent Life Additional Amount of Life Insurance Subject to Medical Underwriting \$_____				
<input type="checkbox"/> Long Term Disability Enrollment Year: _____				

To be Completed by the Proposed Insured / Applicant (A separate form must be completed for each Proposed Insured / Applicant)

Member Name (Must Complete)			First	MI	Last	Member Social Security Number (Must Complete)			
Insurance is for <input type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child		Proposed Insured Name			First	MI	Last	<input type="checkbox"/> Male	Date of Birth (Mo Day Yr)
								<input type="checkbox"/> Female	
Mailing Address					City			State	Zip Code
Business Phone Number ()	Home Phone Number ()	E-mail Address			State of Birth			Country of Birth	

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Medical Information — Please complete all questions below. Omitted information will cause delays. "You" and "Your" refers to the Proposed Insured.

- Height ____ feet ____ inches Weight ____ lbs
- Are you now:

	Yes	No
a. pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
b. taking prescribed medications or on a prescribed diet? If "yes," list: _____	<input type="checkbox"/>	<input type="checkbox"/>
c. receiving or applying for any disability benefits including workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
- In the past 5 years, have you received medical treatment or counseling by a physician for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs? Yes No
- In the past 3 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes," specify date of conviction (Mo./Day/Yr.) _____ Yes No
- Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:

	Yes	No		Yes	No
a. chest pain or heart trouble?	<input type="checkbox"/>	<input type="checkbox"/>	h. colitis, Crohn's or any intestinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
b. high blood pressure, stroke or circulatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	i. Epilepsy, paralysis or dizziness?	<input type="checkbox"/>	<input type="checkbox"/>
c. cancer or tumors?	<input type="checkbox"/>	<input type="checkbox"/>	j. mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. anemia, leukemia or other blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	k. Lyme disease, Epstein-Barr or chronic fatigue syndrome?	<input type="checkbox"/>	<input type="checkbox"/>
e. diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	l. arthritis, carpal tunnel, or any muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>
f. asthma, tuberculosis, pneumonia, or other lung disease?	<input type="checkbox"/>	<input type="checkbox"/>	m. kidney or urinary tract disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. ulcers, stomach or liver disorder?	<input type="checkbox"/>	<input type="checkbox"/>	n. thyroid or other gland disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			o. back, neck or spinal disorder?	<input type="checkbox"/>	<input type="checkbox"/>
- Have you ever been diagnosed or treated by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? Yes No
- Personal Physician: _____ Date and reason for last visit: _____
Address: _____ Phone Number: _____

Give full details for "Yes" answers on the next page.

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SOH/NW

American Federation of Teachers (12/07)

**Make A Copy For Your Records & FAX or MAIL Completed Forms to
the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com**

Give full details for "Yes" answers. If more space is needed for full details, attach a separate sheet, sign and date it.

Question Number	Dates of Treatment	Diagnosis/Condition	Duration	Name of Physician or Name of Clinic or Hospital and Complete Address, Including Zip Code

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Declaration — I have read this Statement of Health and declare that all information given above is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.

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(Member must always sign)	
Signed _____	Date _____
(Proposed Insured if other than Member and at least 18 years of age)	
Signed _____	Date _____

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DEC

SOH/NW

American Federation of Teachers (12/07)

Make A Copy For Your Records & FAX or MAIL Completed Forms to
 the SOH Unit at MetLife, 1-859-225-7909, MetLife, PO Box 14069, Lexington, KY 40512-4069
 For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Authorization

In connection with an enrollment for group insurance, for underwriting and claim purposes regarding the proposed insureds (the proposed insureds are the "employee", spouse, and any other person(s) named below), notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured authorizes:

- Any medical practitioner, facility or related entity; any insurer; the Medical Information Bureau, Inc. (MIB); any employer; any group policyholder, contract holder or benefit plan administrator; 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;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results; and
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Unless permitted by applicable law, the proposed insured 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 the proposed insured obtaining insurance coverage. In all other cases, 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.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Each proposed insured has a right to receive a copy of this form.

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



Signature of Proposed Insured or
Signature & Relationship of Personal Representative*

Print Name of Proposed Insured

Date Signed (Mo./Day/Yr.)

*If a child proposed for insurance is age 18 or over, the child must sign this Authorization. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured.** A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.

Privacy Notice

If you submit a request for insurance (Statement of Health form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of these companies:

Metropolitan Life Insurance Company

Paragon Life Insurance Company

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But depending on the type of product or insurance, we may need more information. This may include information about your finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies. Our affiliates currently include car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- 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 your finances, employment, hobbies, mode of living, work history, and driving record.

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

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: We take steps we consider reasonable to make sure that what we know about you is treated confidentially. For example, our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We also take steps to make our computer databases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

When we disclose information to others to perform business services for us, they are required to take appropriate steps to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If the law allows us to do so, we may disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please visit our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. When writing to us, please identify the specific product or service you are writing about.



Our Privacy Notice

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

Plan Sponsors and Group Insurance Contract Holders

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

Protecting Your Information

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

Collecting Your Information

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

How We Get Your Information

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

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

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

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

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

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

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

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

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

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

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

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long term care, or medical insurance from us, the Health Insurance Portability and Accountability Act ("HIPAA") may further limit how we may use and share your information.

Accessing and Correcting Your Information

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

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

Questions

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

Send privacy questions to:

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

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

**Metropolitan Life Insurance Company
General American Life Insurance Company
SafeGuard Life Insurance Company**

**MetLife Insurance Company of Connecticut
SafeGuard Health Plans Inc.**