AUTHORIZATION TO RELEASE HEALTH RELATED INFORMATION TO MY REPRESENTATIVE

I authorize Metropolitan Life Insurance Company ("MetLife") to disclose information about me, including health related information, to my insurance representative named below for the purpose of providing me with additional information regarding my underwriting classification for this insurance.

_____ _____

(Print name of Representative) *(Print address of Representative)*

The **types of information that may be disclosed** by MetLife pursuant to this Authorization include all health related records about me, which may contain records, test results, and data on my medical care, treatment or surgery; prescription medicines; sexually transmitted diseases, HIV test results, AIDS and HIV related conditions; mental illness, psychiatric or psychological medical records (but not psychotherapy notes); and alcohol or drug abuse information including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws.

In no event will information regarding your health history be disclosed if prohibited by state or federal law.

I understand that:

- **I am not required to sign this Authorization as a condition to my application for long term care insurance from MetLife.**
- Information disclosed pursuant to this Authorization may no longer be subject to MetLife's privacy policy.
- Information that may have been subject to 42 CFR Part 2 or HIPAA privacy rules or other laws, once disclosed, will no longer be covered by those rules and may be subject to re-disclosure by the recipient.
- I have a right to revoke this Authorization at any time and may do so by writing to MetLife, *[provide the address for LTC underwriting]*. I further understand, however, that any action taken by MetLife in reliance on this Authorization prior to receipt of my revocation by MetLife will remain valid.
- This Authorization will be valid for 6 months after the date it is signed below unless revoked by me prior to that time.
- I have a right to receive a copy of this Authorization.

A copy of this Authorization will be as valid as the original.

_____

Signature of Applicant/Proposed Insured

Date ____/____/_____

_____

Printed Name

_____

Address