



# ENROLLMENT • CHANGE FORM

## SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer <b>STAFFORD TOWN AND BOARD OF EDUCATION</b>	Group Customer Number <b>5959058</b>	Division	Class	Dept Code
Date of hire <i>(mm/dd/yyyy)</i>	Coverage Effective Date <i>(mm/dd/yyyy)</i>			

## SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name	Middle Name	Last Name		
SSN	Date of birth <i>(mm/dd/yyyy)</i>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Address	City	State	ZIP	
Job title	Basic annual earnings \$	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Hours worked per week	
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter date <i>(mm/dd/yyyy)</i>				
Phone number	Email address			

- ▶ I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and AD&D. I understand that contributions are required for the benefits I select below.
- ▶ For Minnesota and Vermont State residents - If I am enrolling for Accident Insurance: I declare that all individuals to be insured have comprehensive medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses.
- ▶ I have received and read a copy of the Outline of Coverage or other disclosure document for the Accident Insurance and Specified Disease Insurance.
- ▶ In certain states, this coverage may be referred to as Critical Illness Insurance, Specified Disease Insurance, Limited Benefit Insurance or Limited Benefit Critical Illness Insurance.
- ▶ The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**
- ▶ If you are enrolling after the initial enrollment period, please refer to the Declarations and Signature section of this enrollment form to determine the evidence of insurability and late entrant requirements. If evidence of insurability is required for a coverage you are electing, you must complete a Statement of Health form for all amounts you are requesting.

## Term Life and Accidental Death & Dismemberment (AD&D) Insurance

Basic Life<sup>1</sup> and AD&D (Core)

### GEF02-1 ADM

*(The form number above applies to residents of all states except as follows: Form number GEF02-1 ADM applies to residents of Oregon;*

*GEF09-1 applies to residents of Louisiana and Montana;*

### GEF02-1

*ADM applies to residents of Connecticut, North Dakota, and Utah)*

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## Accident Insurance

Accident Insurance

### Select your level of coverage

- Employee Only  
 Employee + Spouse/Domestic Partner<sup>2</sup>  
 Employee + Child(ren)  
 Employee + Spouse/Domestic Partner<sup>2</sup> + Child(ren)

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## Smoking Status Information for Specified Disease Insurance

Have you smoked cigarettes, pipes or cigars or used tobacco in any form in the past 1 year?

Employee:  Yes  No

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## Specified Disease Insurance

**First select your option**    **Then select your level of coverage**

- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> \$5,000  | <input type="checkbox"/> Employee Only  |
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Employee + Spouse/Domestic Partner <sup>2</sup>              |
| <input type="checkbox"/> \$15,000 | <input type="checkbox"/> Employee + Child(ren)  |
|                                   | <input type="checkbox"/> Employee + Spouse/Domestic Partner <sup>2</sup> + Child(ren) |

<sup>1</sup> 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.

<sup>2</sup> 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**

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**GEF02-1**

*ADM applies to residents of Connecticut, North Dakota, and Utah)*

### SECTION 3: Dependent Information

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

<b>Name of your Spouse/Domestic Partner</b> <i>(first, middle, last)</i>	Date of birth <i>(mm/dd/yyyy)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Name(s) of your Child(ren)</b> <i>(first, middle, last)</i>	Date of birth <i>(mm/dd/yyyy)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> Female
		<input type="checkbox"/> Male <input type="checkbox"/> 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.

#### GEF02-1 ADM

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#### GEF02-1

*ADM applies to residents of Connecticut, North Dakota, and Utah)*

### SECTION 4: Fraud Warnings

Before signing this enrollment 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.

**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 to the extent required by applicable law.

**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.

#### GEF09-1 FW

*(The form number above applies to residents of all states except as follows: Form number GEF09-1 FW applies to residents of Oregon;*

*GEF09-1 applies to residents of Louisiana and Montana;*

#### GEF09-1

*FW applies to residents of Connecticut, North Dakota and Utah)*

**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**

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#### **GEF09-1**

***FW** applies to residents of Connecticut, North Dakota and Utah)*

## SECTION 5: Beneficiary Designation for Employee 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 understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name ( <i>first, middle, last</i> )	SSN	Date of birth ( <i>mm/dd/yyyy</i> )		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name ( <i>first, middle, last</i> )	SSN	Date of birth ( <i>mm/dd/yyyy</i> )		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name ( <i>first, middle, last</i> )	SSN	Date of birth ( <i>mm/dd/yyyy</i> )		Relationship	Share %
Address	City	State	ZIP	Phone number	

**Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%**

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name ( <i>first, middle, last</i> )	SSN	Date of birth ( <i>mm/dd/yyyy</i> )		Relationship	Share %
Address	City	State	ZIP	Phone number	
Full Name ( <i>first, middle, last</i> )	SSN	Date of birth ( <i>mm/dd/yyyy</i> )		Relationship	Share %
Address	City	State	ZIP	Phone number	

**Payment will be made in equal shares or all to the survivor unless otherwise indicated. Total: 100%**

## SECTION 6: Declarations and Signature

**Your Accident and Critical Illness certificate provides limited benefits. Read your certificate carefully.**

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling. 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.

**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 Oregon;

**GEF09-1** applies to residents of Louisiana and Montana;

**GEF09-1**

**DEC** applies to residents of Connecticut, North Dakota and Utah)



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. I understand that if I do not enroll for life coverage during the initial enrollment period, or 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 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.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
7. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
8. I declare that no person proposed for Specified Disease coverage is covered under any Title XIX program (Medicaid or any similarly named program) and that I understand that no person covered under any Title XIX program can be covered under the Specified Disease group policy.

**GEF09-1  
DEC**

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**GEF09-1**

***DEC** applies to residents of Connecticut, North Dakota and Utah)*



Metropolitan Life Insurance Company, New York, NY 10166

9. I have read the applicable Fraud Warning(s) provided in this enrollment form.

<b>Sign Here</b>	Signature of Employee	Date signed ( <i>mm/dd/yyyy</i> )	
	Print First Name	Print Middle Name	Print Last Name

**GEF09-1  
DEC**

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**GEF09-1** *applies to residents of Louisiana and Montana;*

**GEF09-1**

**DEC** *applies to residents of Connecticut, North Dakota and Utah)*

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### **How to submit this form**

After completion, make a copy for your records and return the original to your employer.

**This page intentionally left blank.**



## YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

**Note:** This notice is required by Louisiana law. MetLife does not collect or use genetic information in the sale, issuance, administration, or underwriting of its accidental death & dismemberment, dental, vision, accident and/or hospital indemnity insurance products.

**This notice is in connection with an enrollment in group (accidental death & dismemberment, dental, vision, accident, and/or hospital indemnity) insurance and information regarding your (“employee”, “spouse/domestic partners”, and/or “child (ren)”) rights related to the release and use of genetic information.**

**Genetic Information** is defined as all information about genes, gene products, inherited characteristics, or family history/pedigree that is expressed in common language and **Genetic Information** shall include each of the following:

- an individual's genetic test;
- the genetic tests of the family members of an individual;
- the manifestation of a disease or disorder in family members of an individual;
- with respect to an individual or family member of an individual who is a pregnant woman, genetic information of any fetus or embryo carried by such pregnant woman; and with respect to an individual or family member of an individual utilizing an assisted reproductive technology, genetic information of any embryo legally held by the individual or family member.

**Genetic Information** does not include the medical history of an individual insured or applicant for health care coverage and shall not mean information about the sex or age of any individual.

**Genetic Services** is defined as a genetic test, genetic counseling, including obtaining, interpreting, or assessing genetic information, or genetic education.

**Genetic Test** is defined as any test for determining the presence or absence of genetic characteristics in an individual, including tests of nucleic acids, such as DNA, RNA, and mitochondrial DNA, chromosomes, or proteins in order to diagnose or identify a genetic characteristic or that detects genotypes, mutation, or chromosomal changes. The determination of a genetic characteristic shall not include any diagnosis of the presence of disease, disability, or other existing medical condition.

**Genetic Test** shall not mean an analysis of proteins or metabolites that either:

- does not detect genotypes, mutations, or chromosomal changes;
- is directly related to a manifested disease, disorder, or pathological condition that could be reasonably detected by a health care professional with appropriate training and expertise in the field of medicine involved.

Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife's behalf in this regard shall **not**:

- request, require, or purchase genetic information of an individual or family member of an individual for underwriting purposes;
- request, require, or purchase genetic information of an individual or family member of an individual prior to such individual's enrollment under the plan or coverage in connection with such enrollment;
- request or require that an individual, a family member of such individual, or a group member undergo a genetic test;
- establish rules for eligibility, including continued eligibility, of any individual or an individual's family member to enroll or continue enrollment based on genetic information;
- impose any preexisting condition exclusion on the basis of genetic information of an individual, family member of an individual, or group member;
- adjust premium or contribution amounts for an individual or group health plan on the basis of genetic information concerning the individual or a family member of the individual.

## **YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION**

MetLife or any third party acting on MetLife's behalf is not precluded from obtaining and using the results of a genetic test in making a determination regarding payment. MetLife or any third party acting on MetLife's behalf may request, but not require, that an individual, family member of an individual, or a group member undergo a genetic test if:

- Compliance with the request is voluntary.
- Noncompliance will have no effect on enrollment status or premium, or contribution amounts.

MetLife or any third party acting on MetLife's behalf in this regard which is offering health insurance coverage obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation. The results of any genetic test, including genetic test information, shall not be used as the basis to:

- terminate, restrict, limit, or otherwise apply conditions to the coverage of an individual or family member under the policy or plan, or restrict the sale of the policy or plan to an individual or family member;
- cancel or refuse to renew the coverage of an individual or family member under the policy or plan;
- deny coverage or exclude an individual or family member from coverage under the policy or plan;
- impose a rider that excludes coverage for certain benefits or services under the policy or plan;
- establish differentials in premium rates or cost sharing for coverage under the policy or plan;
- otherwise discriminate against an individual or family member in the provision of insurance.

MetLife or any third party acting on MetLife's behalf in this regard, offering health insurance coverage may request only the minimum amount of information necessary to accomplish the intended purpose.

Nothing shall be construed to limit the authority of a health care professional who is providing health care services to an individual to request that such individual undergo a genetic test.



Delaware American Life Insurance Company  
MetLife Legal Plans, Inc.  
MetLife Legal Plans of Florida, Inc.  
MetLife Health Plans, Inc.

Metropolitan Life Insurance Company  
Metropolitan Tower Life Insurance Company  
SafeGuard Health Plans, Inc.  
SafeHealth Life Insurance Company

## Our Privacy Notice

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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.

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### 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, or as an executive benefit. In this notice, "you" refers to these individuals.

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### 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.

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### 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, car, and home insurers. They also include a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

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### 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, Inc. ("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, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at [www.mib.com](http://www.mib.com).

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## 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

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## 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

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## 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](http://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](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

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## 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.

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## 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](mailto: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.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**  
**THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**  
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This insurance provides limited benefits, if you meet the conditions listed in the certificate, for hospital or medical expenses that result from accidental injury or sickness. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays:**

- hospital or medical expenses up to the maximum stated in the certificate

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

**BEFORE YOU BUY THIS INSURANCE**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP)

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

Some health care services paid for by Medicare may also trigger the payment of benefits from this certificate.

This insurance pays a fixed amount, regardless of your expenses, if you meet the certificate conditions, for one of the specific diseases or health conditions named in the certificate. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D  
other approved items and services

This certificate must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**BEFORE YOU BUY THIS INSURANCE**

- ✓ Check the coverage in all health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).