Disability Insurance Plan

MetLife

Endorsed by
MEMBER BENEFITS
nysut
Working to Benefit You

NYSUT MEMBER BENEFITS HAS PARTNERED WITH METLIFE TO OFFER YOU A RANGE OF DISABILITY PLANS. YOU CAN CHOOSE THE BENEFIT AMOUNT AND WAITING PERIOD THAT IS RIGHT FOR YOU

NYSUT Member Benefits Trust-endorsed Disability Plan

You've probably insured your car, your home and your life, so now is the time to insure your salary with Disability Insurance. We don't want you to lose your income if you suddenly had to stop working due to an accident or illness. Disability Insurance will ensure you still receive part of your salary, so you can continue paying your bills and providing for your family. Plus, you'll also be able to take advantage of rehabilitation programs with financial incentives.

This Disability Insurance can help you protect your income with a Short-Term, Long-Term or 5-Year Disability Plan.

You can customize your own plan. You choose from varying benefit amounts and waiting periods to suit your personal income protection needs, as outlined in this brochure.

The plan also provides hospital confinement benefits and accidental death and dismemberment. Take a minute to see how Disability Insurance can help you.

This information is only a brief description of the principal provisions and features of the plan. The complete terms and conditions are set forth in the Certificate of Insurance issued by MetLife.

ARE YOU ELIGIBLE?

You may apply for this coverage if:

- You are a member of, or agency fee payer to, NYSUT.
- You are age 65 or under.
- You work 20 or more hours weekly.

Lawful spouses or domestic partners of NYSUT members, retiree members and Associate Members of NYSUT are not eligible for this plan.

CREATE YOUR OWN PLAN IN THREE EASY STEPS

Create a plan that best suits your needs. Start by examining whether you presently have disability coverage and the benefits you would need if a disabling illness or injury strikes. Consider factors such as the type of income protection benefits, if any, your employer offers; the amount of sick leave you've accrued; your age; your years to retirement; and the amount of money you have in savings.

STEP 1. Choose Your Benefit Duration.

You may select among three plans:

- **Long-Term Plan:** If you do not already have coverage for longer periods of disability – 5, 10, 15 years or longer – you probably need the kind of income protection offered by the Long-Term Plan.
- **5-Year Plan:** If you're looking for affordable coverage and are several years away from retiring, you may want to consider the 5-Year Plan.
- **Short-Term Plan:** If you are looking for short-term coverage to cover sick leave or are nearing retirement, you may need the short-term, 12-month disability plan.

Plan	Start of Total Disability	Maximum Benefit Period
Long-Term	Prior to age 64 Age 64 or over	To age 65 12 months
5-Year	Prior to age 64 Age 64 or over	60 months 12 months
Short-Term	Prior to age 64 Age 64 or over	12 months

Unless otherwise indicated, information in this brochure applies to all plans.

STEP 2. Choose Your Benefit Amount.

You may apply for $500 to $5,000 per month (in $50 monthly benefit units), not to exceed 60 percent of your gross monthly earnings. You can increase your coverage amount in the future if your salary increases, but you will need to reapply for additional benefits. Benefits under the Member Benefits endorsed Disability Insurance Plan may be tax-free under current tax law if premium is paid with after-tax dollars. Please consult and discuss this with your tax advisor.

If you become totally disabled while insured, the plan will pay the monthly benefit amount you are issued, starting the first day following completion of the waiting period you selected (see STEP 3). If you remain totally disabled, the plan will continue to pay the monthly benefit, not to exceed the maximum benefit period, subject to the coordination of benefits provision described later.

STEP 3. Choose Your Waiting Period.

The waiting period, also known as the elimination period, is the amount of time you must be totally disabled due to a covered sickness or injury before benefits will begin to be paid. The waiting period begins on the first day you are totally disabled.

You may select a waiting period of 60, 90, 120, 150 or 180 calendar days. The longer the waiting period, the lower your premium payments will be.

EXPLANATION OF DISABILITY INSURANCE PLAN BENEFITS

Coordination of Loss of Income Benefits

We will reduce your disability benefit by the amount of all other income benefits you receive that includes but is not limited to Social Security, workers' compensation, and any income received for disability under a group insurance policy, such as benefits for loss of time from work due to disability installment payments for permanent total disability. More reductions may apply. Please review your certificate for full details.

Minimum Benefit Guarantee

$500 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate.

Effective Date of Insurance

The insurance takes effect on the date shown on the Certificate of Insurance sent to you, if you are actively at work, provided we have approved your application and subject to your payment of the required premium. If you are not actively at work on that date, the insurance will take effect on the date you are actively at work, as long as it is within three months of the Certificate effective date and you are still eligible for coverage. If your insurance is scheduled to take effect on a non-working day, your Active Work status will be based on whether you were Actively at Work on the last working day before the scheduled Effective Date of your insurance.

Definition of Total Disability

"Total Disability" means you can't perform the duties of your regular occupation during the first 24 months for the Long-Term and 5-Year Plans, following completion of the waiting period you have chosen. After 24 months, your disability must prevent you from engaging in any occupation for which you are reasonably suited. For the Short-Term Plan, "Total Disability" means you can't perform the duties of your regular occupation during the first 12 months. For all three plans, you must be receiving medical care from a physician during total disability.

Voluntary Accidental Death & Dismemberment (VAD&D)

This Disability Insurance provides an accidental death & dismemberment benefit at no additional cost.
Principal Sum $25,000

Hospital Confinement Benefit

The VADD benefit includes a hospital confinement benefit. If hospital confinement occurs within 12 months of an accidental injury, benefits paid are up to $250 maximum per month. Benefits will begin on the 5th day of confinement and will continue for a maximum of 12 months. Please refer to the VAD&D portion of your Disability Certificate for coverage details.

Waiver of Premium

If you become totally disabled and are receiving monthly benefits from your plan, future premiums will be waived. The waiver of premium will stop when you are no longer eligible to receive a monthly benefit for the period of total or partial disability.

Disability Due to Mental Disorders Limitation

The plan limits monthly benefits for mental disorders to a Maximum benefit period of 12 months.

Termination of Disability Benefits

Disability benefits will stop on the earliest of: the date you are no longer totally disabled or partially disabled; the date of your death; or the end of the maximum benefit period for total or partial disability or for mental disorders.

Termination of Insurance

The Covered Person's insurance will terminate on the earliest of the following dates: 1.) The date the Group Policy terminates; 2.) The date on which the Covered Person retires or ceases to be actively engaged in his or her occupation for remuneration or profit, except by reason of Total Disability as defined; 3.) The date on which the Covered Person ceases to be a member of a class of Eligible Persons; 4.) The date on which the Covered Person attains the Age Limit of 66 years of age; or 5.) The end of the grace period following the last day of the period for which a premium payment is made. Any unearned premium paid beyond a termination date will be promptly refunded on a prorated basis.

30-Day Free Look

When you become insured, you will be sent a schedule of benefits summarizing your insurance coverage and how to obtain your Certificate of Insurance. If you are not completely satisfied with the terms of your Certificate, you may contact Mercer Consumer toll-free at 888-386-9788, without claim within 30 days. Your coverage will be void from the start and you will receive a full refund—no questions asked!

PREMIUM PAYMENT OPTIONS AND RATES

You may select from the following convenient payment options:

- Payroll deduction.*Note: You can gain a discount on premiums of up to 20 percent if you select the payroll deduction option for the Long-Term or 5-Year Plan!
- Pre-authorized check draft.
- Direct bill on an annual, semi-annual or quarterly basis.

Rates for these payment options are outlined on the following charts. Charts 1 and 2 outline information for the Long-Term Plan; Charts 3 and 4 provide information for the 5-Year Plan; and Charts 5 and 6 provide information on the Short-Term Plan.

HOW TO CALCULATE YOUR PREMIUMS

Complete Steps 1 through 3, (on previous pages), then:

- Determine the number of $50 monthly benefit units (as described in Step 2) that your plan will provide.
- Multiply this amount by the monthly premium contribution per unit, based on your age and the waiting period you selected.

Example: You are age 35 and will use the payroll deduction option. You've selected the Long-Term Plan (see Chart 1), a $2,000 monthly benefit and a 90-day waiting period. Check Chart I for the applicable rates based on your selections.

Rate/$50 monthly benefit	**x**	**# of $50 units**	**=**	**Monthly Premium**
$.60 (from chart I)	x	40 units	=	$24

If you select the Pre-Authorized Check Plan (ACH) instead of the Payroll Deduction Option…obtain your information from Chart 2. Multiply $.75 by the 40 units, for a monthly premium of $30.

If you elect to pay semi-annually…multiply this $30 monthly rate, as calculated above, by six months, for a semi-annual premium of $I80.

Premiums are based on your age at the time coverage becomes effective, and they increase on the premium due date on or after you reach a higher age bracket.

* Payroll deduction is available in local associations that have made the necessary arrangements for payroll deductions of Member Benefits-endorsed programs.

LONG-TERM PLAN — TO AGE 65

Monthly Premiums Per $50 Monthly Benefit From $500 to $5,000, not to exceed 60 percent of gross monthly earnings. Rates Shown Per Waiting Period

Chart 1 — Payroll Deduction Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.64	$ 0.60	$ 0.56	$ 0.52	$ 0.48
40–49	1.08	1.00	0.96	0.88	0.84
50–59	1.64	1.44	1.40	1.28	1.24
60–65	1.84	1.60	1.48	1.40	1.28

Chart 2 — Direct Bill Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.80	$ 0.75	$ 0.70	$ 0.65	$ 0.60
40–49	1.35	1.25	1.20	1.10	1.05
50–59	2.05	1.80	1.75	1.60	1.55
60–65	2.30	2.00	1.85	1.75	1.60

5-YEAR PLAN

Monthly Premiums Per $50 Monthly Benefit From $500 to $5,000, not to exceed 60 percent of gross monthly earnings. Rates Shown Per Waiting Period

Chart 3 — Payroll Deduction Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.56	$ 0.40	$ 0.37	$ 0.32	$ 0.30
40–49	0.90	0.80	0.76	0.69	0.68
50–59	1.40	1.32	1.29	1.26	1.21
60–65	1.84	1.60	1.48	1.40	1.28

Chart 4 — Direct Bill Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.60	$ 0.47	$ 0.44	$ 0.41	$ 0.36
40–49	1.02	0.94	0.90	0.83	0.79
50–59	1.64	1.53	1.46	1.39	1.34
60–65	2.30	2.00	1.85	1.75	1.60

SHORT-TERM PLAN — 12 MONTHS

Monthly Premiums Per $50 Monthly Benefit From $500 to $5,000, not to exceed 60 percent of gross monthly earnings. Rates Shown Per Waiting Period

Chart 5 — Payroll Deduction Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.30	$ 0.20	$ 0.20	$ 0.15	$ 0.15
40–49	0.45	0.35	0.30	0.25	0.25
50–59	0.60	0.50	0.50	0.45	0.40
60–65	1.15	1.00	0.90	0.85	0.75

Chart 6 — Direct Bill Option

Age	60-Day	90-Day	120-Day	150-Day	180-Day
18–39	$ 0.30	$ 0.20	$ 0.20	$ 0.15	$ 0.15
40–49	0.45	0.35	0.30	0.25	0.25
50–59	0.65	0.55	0.50	0.45	0.40
60–65	1.20	1.05	0.95	0.90	0.80

ADDITIONAL DISABILITY PLAN DETAILS

The MetLife Disability Plan includes services to help you get back to work. The services can include:

Nurse Consultant or Case Manager Services
Specialists who personally contact you, your physician and your employer to coordinate an early return-to-work plan when appropriate.

Vocational Analysis
Help with identifying job requirements and determining how your skills can be applied to a new or modified job with your employer.

Job Modifications/Accommodations
Recommending adjustments (e.g., redesign of work station tools) that enable you to return to your previous job or a similar one.

Retraining
Development programs to help you return to your previous job or educate you for a new one.

Financial Incentives
Allow employees to receive Disability benefits or partial benefits while attempting to return to work.

The Services of Social Security Specialists
Once you are approved for Long-Term Disability benefits, MetLife can help you obtain Social Security Disability benefits. Our specialists can guide you through the initial application and appeals processes and may also help you access assistance from attorneys or vendors to pursue Social Security benefits.

How do I apply for coverage?
Apply by completing the enclosed enrollment form and mailing it to the address on the bottom of the form.

How is disability defined under this plan?
Generally, you are considered disabled and eligible for Long-Term benefits if, due to sickness, pregnancy or accidental injury, you are receiving appropriate care and treatment, complying with the requirements of treatment and you are unable to earn more than 60% of your pre-disability earnings at your own occupation for any employer in your local economy.

When do benefits begin and how long do they continue?
Benefits begin after the end of the elimination period. The elimination period begins on the day you become disabled and is the length of time you must wait while being disabled before you are eligible to receive a benefit. Your elimination period for Disability is chosen by you when you enroll. You may choose 60, 90, 120, 150 or 180 calendar days. Your plan's maximum benefit period and any specific limitations are described in the Certificate of Insurance.

Can I receive benefits if I return to work part-time?
Yes, as long as you are disabled and meet the terms of your Disability plan, you may qualify for adjusted Disability benefits.

Are there any exclusions or limitations to my coverage?
Yes. The following limitations and exclusions apply.

Limited Disability Benefits
For Disability Due to Alcohol, Drug or Substance Abuse or Addiction
If you are Disabled due to alcohol, drug, or substance abuse or addiction, we will limit your Disability benefits to one period of Disability during your lifetime. During your Disability, we require you to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician.

We will end Disability benefit payments at the earliest of:

- the date you receive 24 months of Disability benefit payments;
- the date you cease or refuse to participate in the recovery program referred to above; or
- the date you complete such recovery program.

For Disability Due To Mental and Nervous Disorders or Diseases; Neuromuscular, Musculoskeletal or Soft Tissue Disorders, Chronic Fatigue Syndrome and Related Conditions, or Fibromyalgia

If you are Disabled due to one or more of the following medical conditions described below, we will limit your Disability benefits to a lifetime maximum equal to the lesser of:

24 months; or
the Maximum Benefit Period.

Subject to the Administration of Limited Disability Benefits for Disability Due to Mental and Nervous Disorders or Diseases, Neuromuscular, Musculoskeletal, or Soft Tissue Disorders, Chronic Fatigue Syndrome and Related Conditions, or Fibromyalgia provision set forth below:

Your Disability benefits will be limited as stated above for:

1. Mental or Nervous Disorder or Disease that results from any cause, except for:
   Neurocognitive Disorders;
   Schizophrenia; or
   Bipolar I Disorder.

2. Neuromuscular, Musculoskeletal or Soft Tissue disorders including, but not limited to, any disease or disorder of or injury to the spine or extremities and their surrounding soft tissue; sprains or strains of joints or their adjacent muscles, Carpel Tunnel Syndrome or other Repetitive Motion Disorders, unless the Disability has objective evidence of:
   Myelopathies;
   Myopathies;
   Connective Tissue Disorder or Disease;
   Tumors of the spine, bone or soft tissue;
   Spinal Vascular Malformations; or
   Spinal Cord Damage;
3. Chronic Fatigue Syndrome and Related Disorders;
4. Fibromyalgia.

Administration of Limited Disability Benefits for Disability due to Mental and Nervous Disorders or Diseases, Neuromuscular, Musculoskeletal, or Soft Tissue Disorders, Chronic Fatigue Syndrome and Related Conditions, or Fibromyalgia

If no exception above applies, and you are Disabled as a result of:

- more than one injury or Sickness for which Disability benefits are payable under this certificate, each of which are subject to the provisions of the Limited Disability Benefits section, the benefit limitation periods will run concurrently for all such conditions.
- one or more injuries or Sicknesses for which a Disability benefit is payable under this certificate, one or more of which is subject to the provisions of the Limited Disability Benefits section, your Disability benefits will terminate at the end of the limitation period shown above, unless We receive Proof that You are Disabled at the end of such limitation period due to one or more of the exceptions to the limitation shown above, or to a Sickness or injury not subject to the limitations in Limited Disability Benefits.

Defined Terms Used in Limited Disability Benefits

Bipolar I Disorder means a psychiatric disorder diagnosed in accordance with the diagnostic criteria for Bipolar I Disorder set forth in the most recent edition of the DSM as of the date of your Disability. Supporting documentation must include evidence that you experienced at least one full manic episode. The following conditions, as determined using the diagnostic criteria for such conditions set forth in the most recent edition of the DSM as of the date of your Disability, are not considered Bipolar I Disorder for purposes of this exclusion:

- Bipolar II disorder;
- Cyclothymic disorder;
- Substance induced bipolar disorder;
- Bipolar disorder associated with a known general medical condition;
- Other specified bipolar disorder; or
- Unspecified bipolar disorder.

Carpel Tunnel Syndrome
means an entrapment median neuropathy, which causes pain, numbness, and other symptoms in the distribution of the median nerve due to its compression at the wrist.

Chronic Fatigue Syndrome
means the clinically evaluated, unexplained persistent or relapsing chronic fatigue that is not substantially alleviated by rest. The diagnosis must be established following the Centers for Disease Control current clinical criteria as of the date of your Disability.

Connective Tissue Disorder or Disease
means any of a group of diseases affecting the connective tissues of the body. These conditions include, but are not limited to, rheumatoid arthritis, Marfan syndrome, systemic lupus erythematosus, scleroderma, Ehlers-Danlos syndrome or polymyositis.

The diagnosis must be established using American College of Rheumatology current clinical criteria as of the date of your Disability.

Fibromyalgia
means a medical condition evidenced by widespread soft tissue pain. The diagnosis must be established following the American College of Rheumatology current clinical criteria as of the date of your Disability.

Mental or Nervous Disorder or Disease
means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") as of the date of your Disability.

Musculoskeletal
means the bones, joints, joint capsules, cartilage, or adjacent tendons, ligaments or muscles.

Myelopathies
means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Myopathies
means diseases of muscle fibers, supported by pathological findings on biopsy or electromyography (EMG).

Neurocognitive Disorder
means a condition that meets the diagnostic criteria for neurocognitive disorders set forth in the most recent edition of the DSM as of the date of your Disability, and the cognitive deficits that relate to the Disability are not attributable to another Mental or Nervous Disorder or Disease. Neurocognitive disorders include, but are not limited to, conditions such as Alzheimer's disease and other forms of dementia, and Traumatic Brain Injury.

Neuromuscular
means the peripheral motor nerves and the muscles that such nerves supply.

Related Disorders
means conditions that are similar to Chronic Fatigue Syndrome in that the symptoms associated with the condition are comparable. These conditions include, but are not limited to, the following:

- Chronic Fatigue Immunodeficiency Syndrome;
- Post Viral Syndrome; and
- Epstein-Barr virus infection.

The diagnosis must be established following the Centers for Disease Control current clinical criteria as of the date of your Disability.

Repetitive Motion Disorders means muscular conditions that result from repeated motions performed in the course of normal work or daily activities and affecting upper or lower extremities.

Schizophrenia means a chronic psychiatric disorder diagnosed in accordance with the diagnostic criteria for Schizophrenia set forth in the most recent edition of the DSM as of the date of your Disability.

Self-Reported Condition means the symptoms and other manifestations of your condition that are not objectively verifiable using tests, procedures and clinical examinations that are standardly accepted in the practice of medicine. Self-Reported Conditions include, but are not limited to, conditions such as migraine and other types of headaches, symptoms of pain, fatigue, stiffness, soreness, ringing in ears, dizziness or vertigo, numbness, impaired concentration, and loss of energy.

Seropositive Arthritis means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

Soft Tissue means the muscle, fat, fibrous tissues, and blood vessels, which connect, support, or surround the bony structures and organs of the body.

Spinal means components of the bony spine or spinal cord.

Spinal Cord Damage means injury or disease of the spinal cord with resultant paralysis.

Spinal Vascular Malformations means abnormal development of blood vessels within the spinal cord.

Tumor(s) means abnormal growths which may be malignant or benign.

Disability Income Insurance Exclusions:
We will not pay for any Disability caused or contributed to by:
1. War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
2. Your active participation in a riot;
3. Intentionally self-inflicted injury;
4. Attempted suicide; or
5. Commission of or attempt to commit a felony.

We will not pay Benefits for any Disability caused or contributed to by elective treatment or procedures, such as:
1. Cosmetic surgery or treatment primarily to change appearance;
2. Sex-change surgery;
3. Reversal of sterilization;
4. Liposuction;
5. Visual correction surgery; and
6. In vitro fertilization, embryo transfer procedure or artificial insemination.

However, pregnancies and complications from any of these procedures will be treated as a Sickness.

Voluntary Accidental Death & Dismemberment Exclusions:
We will not pay benefits under this section for any loss caused or contributed to by
1. Physical or mental illness or the diagnosis or treatment of such illness;
2. Infection, other than infection occurring in an external accidental wound or from food poisoning;
3. Suicide or attempted suicide;
4. Intentionally self-inflicted injury;
5. Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
6. Any incident related to: (a) travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; (b) travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in (c) flight; (d) parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self preservation; (e) travel in an aircraft or device used for testing or experimental purposes, by or for any military authority or for travel or designed for travel beyond the earth's atmosphere;
7. Committing or attempting to commit a felony;
8. The voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician or an "over the counter" drug, medication or sedative taken as directed; alcohol in combination with any drug, medication, or sedative or poison, gas, or fumes;
9. War, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

* Additional limitations or exclusions to your coverage may apply. Please review your Certificate of Insurance or contact your benefits administrator with any questions.

HOW TO APPLY

STEP 1 — Determine the benefit duration (Long-Term, 5-Year or Short-Term), benefit amount, waiting period and payment option you wish to request.

STEP 2 — Complete the attached application form and, if applicable, the Member Benefits Payroll Deduction Authorization Card (if you're requesting the payroll deduction payment option).

STEP 3 — Mail your completed form(s) to:

Plan Administrator
P.O. Box 9186
Des Moines, IA 50306-8838

The MetLife Disability Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

Administered by:
Mercer Consumer,
a service of Mercer Health & Benefits Administration LLC
P.O. Box 9186
Des Moines, IA 50306-8838

AR Insurance License #100102691 CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

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

QUESTIONS? CALL US!

A licensed representative will be happy to assist you with any questions you may have. Call Mercer Consumer toll-free at 888-386-9788, weekdays from 9 a.m. to 9 p.m. or Saturdays from 9 a.m. to 2 p.m. (EST) closed Sunday. You may also visit the website at www.nysutmbteinsurance.com. Email: customerservice.service@mercer.com

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Remember – if you are applying through payroll deduction, complete the Payroll Deduction Authorization Card.

MEMBER BENEFITS

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The Plan Brochure provides only a brief overview of the Disability plans. A more complete description of the benefits provisions, conditions, limitations and exclusions will be included in the Certificate of Insurance. If any discrepancies exist between this information and the legal plan documents, the legal plan documents will govern. Like most group disability insurance policies, MetLife group policies contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force. Contact the plan administrator Mercer Consumer for complete costs and details.

MetLife

ADF# DI1790.17

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION

Name of Policyholder:	Group Customer #
NYSUT Member Benefits Trust	**35370**

Source Code (Office Use Only):

- ☐ 53017/53018/1001/53058 - NYSUT DB
- ☐ 53019/53020/1002/53058 - NYSUT PRD
- ☐ 53023/53024/1003/53058 - UFT DB
- ☐ 53025/53026/1004/53058 - UFT PRD

MEMBER ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Phone #	Email Address	

NYSUT Member ID #	Date of Membership (MM/DD/YYYY)	Basic Annual Earnings:

Job Title	Hours Worked Per Week	Employer:	☐ New Enrollment ☐ Change in Enrollment

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that if I'm enrolling in Long Term Disability Insurance I am also enrolled in Voluntary AD&D Insurance. I understand that contributions are required for the benefits I select below.

If you enroll for certain Contributory Insurance, a portion of your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Policyholder's Group Insurance Program.

Long Term Disability Income Insurance

Select your monthly benefit:

☐ Enter a multiple of $50 (minimum amount is $500) $ _____

The maximum monthly benefit amount age 65 and under is $5,000, not to exceed 60% of your Basic Annual Earnings.

Indicate your waiting period:

☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days

Select Benefit Period:

☐ 12 months ☐ 60 months ☐ Long-Term

Accidental Death & Dismemberment (AD&D) Insurance

☒ Voluntary AD&D -$25,000

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*; and
GEF02-1
ADM *applies to residents of 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:
Mercer Consumer, P.O. Box 9186, Des Moines, IA, 50306-9186.

Please note that coverage may not be available in all states. See your plan administrator for additional information.

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

HEALTH INFORMATION (To be Completed by the Member)

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.

Your Name _____ Your Social Security/Identification # _____

Your height _____ feet _____ inches Your weight _____ pounds

	Yes	No
1. Are you now pregnant?	☐	☐
2. 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?	☐	☐
3. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
4. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:		
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkin's disease, lymphoma or tumors?	☐	☐
e. diabetes?	☐	☐
f. asthma, COPD, emphysema or other lung disease?	☐	☐
g. ulcers, stomach, hepatitis or other liver disorder?	☐	☐
h. colitis, Crohn's, diverticulitis or other intestinal disorder?	☐	☐
i. epilepsy, paralysis, seizures, dizziness or other neurological disorder?	☐	☐
j. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
k. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
l. back, neck, knee, spinal, joint or other musculoskeletal disorder?	☐	☐
m. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
6. Are you currently taking any other prescribed medications?	☐	☐

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

7. In the past 3 years, have you been **Hospitalized** as defined below (not including well-baby delivery)?	☐	☐
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.		
8. In the past 2 years, have you used tobacco or nicotine in any form?	☐	☐

If you answered "yes" to any of the above questions, a Statement of Health form must also be completed for the person to whom the "yes" applies.

GEF09-1
HEA-SUPP
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana*; and **GEF09-1**
HEA-SUPP *applies to residents of North Dakota and Utah)*

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.

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 Benefits): 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*; and
GEF09-1
FW *applies to residents of North Dakota and Utah)*

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

BENEFICIARY DESIGNATION

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.

☐ 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

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical 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 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.
3. I understand that 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.
4. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

New York (only applies to Accident and Health Benefits): 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.

Sign Here

Signature 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*; and **GEF09-1 DEC** *applies to residents of North Dakota and Utah)*

NYSUT
LMI-EF-NY (12/17)

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)("employee", spouse, and 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, Group Inc. ("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, 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;
  - 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, your employer for a plan administration purpose 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.
- 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		Date Signed (MM/DD/YYYY)
Print Name	State of Birth	Country of Birth

Premium Mode / Payment Option Section:
Select one mode of payment: ☐ Payroll Deduction (Please complete the Payroll Deduction Authorization) ☐ Direct Bill Quarterly ☐ Direct Bill Semi-Annually ☐ Direct Bill Annually ☐ Pre-Authorization Check Plan: I would like the Plan Administrator to deduct from my checking account the monthly premium for my NYSUT Member Benefits-endorsed Disability Insurance Plan. I have attached a voided personal check for the checking account from which I want these further deductions made. I understand that by signing up for the Pre-Authorized Check Plan, I will no longer receive a notice of premium due for my insurance premiums, and that this process will continue until I notify the Plan Administrator in writing to terminate the deduction.

The MetLife Disability Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

NYSUT MEMBER BENEFITS PAYROLL DEDUCTION AUTHORIZATION

NYSUT Member Benefits Trust **NYSUT Member Benefits Corporation** **NYSUT Member Benefits CMM Insurance Trust**

MEMBER BENEFITS nysut Working to Benefit You

(Please Print):

Last Name_____ First_____ Middle Initial____

Address_____ NYSUT ID #_____

Home Phone # _____Member's SS #_____

I hereby authorize my employer to deduct from each of my salary checks the deductions necessary for the purpose of NYSUT Member Benefits. Depending on the NYSUT Member Benefits program(s) which I am currently enrolled in and that deductions are taken for, monies will be forwarded to the appropriate NYSUT Member Benefits entity. For insurance plans, I understand that this authorization may be revoked at any time by written notice to the Plan Administrator. For plans with annual fees, I understand that I must provide written notice to the Plan Administrator to cancel automatic renewal and that I must satisfy the annual fee.

Signature of Employee_____ **Date**_____

Mail this completed form with your invoice to the address on the invoice. Please call 800-626-8101 with any questions.

Please check your union membership affiliation:

❒ *UFT* ❒ *UUP* ❒ *PSC/CUNY** ❒ *All other NYSUT Locals*

The amount of deductions will be determined by NYSUT Member Benefits based on the programs chosen, and may be adjusted to ensure that premiums are paid in full.

**This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.*

1.5K, 5-16 I-05

MetLife

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, group insurance or annuity contract, or as an executive benefit. 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 legal plans company and a securities broker-dealer. 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. 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

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.

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 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.

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. 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
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
Delaware American Life Insurance Company
MetLife Health Plans, Inc.
General American Life Insurance Company
SafeHealth Life Insurance Company

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, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. 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. 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.