MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for Group Insurance to provide coverage for the class(es) of persons specified below.

APPLICANT DATA

1. Full legal name of Applicant: _____ (the "Policyholder")

2. Address: _____ City _____ State _____ Zip _____

EFFECTIVE DATE

The effective date of the applied for group insurance will be _____, subject to MetLife's acceptance of this application and the applicant's payment of the Premium due on or before such date.

SITUS

Group Policy forms will be issued for delivery in and governed by the laws of California.

COVERAGE DATA

Employees / Members	Dependents

PREMIUM DATA

Premiums will be paid: ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

Attached is an advance payment of: $_____.

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of all Group Policy forms issued pursuant to this application; including all Exhibits, amendments and endorsements, if any.

Fraud Warning. 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.

_____ _____
(Signature of Applicant's Authorized Representative) (Print Name and Title of Authorized Representative)

Signed at: _____ Date: _____
(City) (State)

_____ _____
(Signature of Licensed MetLife Agent or Resident Agent as required by law) (Agent's State License No.) (Print Name of Agent)

DHMO Dental Only

MetLife®

Benefits provided by SafeGuard Health Plans, Inc.,
a MetLife company
200 Park Avenue, New York, New York 10166

APPLICATION FOR GROUP DENTAL BENEFITS

The applicant named below is applying for a Group Contract to provide dental benefits for the persons specified below.

APPLICANT DATA

1. Full legal name of Applicant: _____
2. Address: _____

   City: _____ State: _____ Zip: _____

CONTRACT EFFECTIVE DATE

The Group Contract's effective date will be _____, subject to MetLife's acceptance of this application.

CONTRACT SITUS

The Group Contract will be issued for delivery in and governed by the laws of California.

COVERAGE DATA	Employees / Members Only	Employees / Members and Dependents
Dental Benefits	☐	☐

PREPAYMENT FEE DATA

Prepayment Fees will be paid: ☐ monthly ☐ quarterly ☐ annually ☐ other: _____

Attached is an advance payment of: $_____

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of the Group Contract, including its Exhibits, amendments and endorsements, if any.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

_____ _____
(Signature of Applicant's Legal Representative) (Print Name and Title of Legal Representative)

Signed at: _____ Date: _____
(City) (State)

_____ _____
(Signature of Witness) (Print Name of Witness)

Isaac Torres

_____ Assistant Vice President Isaac Torres
(SafeGuard Representative) (Representative's title) (Print Name of Representative)

MetLife

Specialty Markets New Group Submission Form

CUSTOMER INFORMATION

Legal Name of Company: _____

Legal Address of Company (No PO Boxes): _____

Address Line 2: _____

City, State, Zip: _____

Employer Tax Identification Number (TIN): _____

SIC Code used to Rate Group: _____ Year Company Founded: _____

Effective Date: _____ **Broker Due Date: Next Business Day**

Number of eligible employees: _____

Coverage(s) sold:

- Basic Life/AD&D
- Supplemental Life/AD&D
- PPO Dental
- DHMO
- Long Term Disability
- Short Term Disability
- Vision
- MetLaw (must sell MetLife Dental or have MetLife Dental in-force)

Will MetLife be taking over voluntary elections from a prior carrier? If yes, a prior carrier's bill showing individual elections is required with submission. Yes No

Does this group have existing coverage with MetLife? If yes, please include the group #: _____

BROKER INFORMATION

Broker First and Last Name: _____

Social Security #: _____

Corporation Name: _____

Federal Tax ID: _____

Resident State: _____

Broker Address 1: _____

Broker Address 2: _____

Broker City, State, Zip: _____

Broker Contact Name: _____ Phone: _____ Email: _____

Is Broker Appointed with MetLife? Yes | No If no or unsure, please contact your MetLife Implementation team.

Commissions Paid to: Writing Producer Brokerage

GENERAL AGENCY INFORMATION (IF APPLICABLE)

General Agency Name (must be different than Broker corporation name above): Beere & Purves Inc.

General Agency Writing Producer's Name (must be different than Broker's name above): Philip Gee Tan, BKR4030270

General Agency Writing Producer's Social Security #: _____

GA Sales Office:[1] _____

General Agency Contact Name: _____ Phone: _____ Email: _____

[1] For GA's with multiple locations, please specify which GA sales office/location is attached to this sold case

Do you have an existing Broker or GA MetLink account? ☐ Yes (*if yes, please provide the MetLink id)* ☐ No

User First and Last Name: _____

User Email: _____

TPA INFORMATION (IF APPLICABLE)

TPA Name : _____

TPA Writing Producer First and Last Name: _____

TPA Writing Producer's Social Security #: _____

TPA Sales Office:[2] _____

TPA Contact Name: _____ Phone: _____ Email: _____

[2] For TPA's with multiple locations, please specify which TPA sales office/location is attached to this sold case

METLIFE SALES INFORMATION

MetLife Local Office
(to be completed by MetLife): _____

MetLife RMAE
(to be completed by MetLife): _____

MetLife Small Market AE
(to be completed by MetLife): _____

PRIMARY CONTACT/BENEFIT ADMINISTRATOR INFORMATION

Contact First and Last Name: _____

Billing Address Line 1
(if different than legal address above): _____

Billing Address Line 2: _____

City, State, Zip: _____

Contact Email: _____

Contact Phone: _____

Should this contact have access to: MetLink® ☐ Yes ☐ No

Do you wish for your GA/Broker to have MetLink access to your account? ☐ Yes ☐ No

CUSTOMER EXECUTIVE CONTACT INFORMATION — ☐ Same as Above

Contact First and Last Name: _____

Contact Email: _____

Contact Phone/Fax: _____

Should this contact have access to MetLink®: Yes No

MetLink® – Our Online administration system designed to make benefits administration easier. MetLink provides convenient, real-time access to MetLife's systems – enabling you to efficiently add or modify employees employee information and look up dental or disability claim status. You can also view your current bill on-line, looking up billing history and run a listing of employees that can be reviewed on-line or downloaded into a spreadsheet.

ADDITIONAL SUBSIDIARY / DIVISION / MULTIPLE LOCATION (Legal Names only)

Add Location information if you have employees who are actively at work and are eligible for coverage at additional location(s). (Please do not re-enter HQ address.)

Legal Company Name: _____

Employer Fed Tax ID #: _____ # of participants at this at this location _____

Street Address _____

City _____ State _____ Zip _____

Separate Bill? Yes No

Legal Company Name: _____

Employer Fed Tax ID #: _____ # of participants at this at this location _____

Street Address _____

City _____ State _____ Zip _____

Separate Bill? __ Yes No

BILLING DETAIL

__ List Bill or SAP Bill *(TPA business only)*

DEPARTMENTAL BILLING (Option to produce one bill with employees subtotaled by Location/Division)

__ Yes __ No

Location/ Department Name _____ Department Code to be displayed on bill _____

Location/ Department Name _____ Department Code to be displayed on bill _____

Does this product have multiple classes?* Yes No

If One Class only, please complete the All Employees Eligibility Section below.

If Multiple Classes, please skip All Employees Eligibility section and complete eligibility info for Class 1 and Class 2.

**Multiple classes must be quoted by MetLife Underwriting*

ELIGIBILITY INFORMATION — ALL EMPLOYEES

Class Description: **All Active Full Time Employees** Number of hours worked: **30 hours**

EMPLOYEE WAITING PERIODS

For Present Employees: _____ days/months __ Date Eligible __ First of the Month

For Future Employees: _____ days/months __ Date Eligible First of the Month

PREMIUM CONTRIBUTIONS — ALL EMPLOYEES

Employer Contribution Percentage — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % __ Pre Tax Post Tax	_____ % __ Pre Tax Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

ELIGIBILITY INFORMATION — CLASS 1

Class Description: _____ Number of hours worked: _____ **hours**

EMPLOYEE WAITING PERIODS

For Present Employees: _____ days/months Date Eligible First of the Month

For Future Employees: _____ days/months Date Eligible First of the Month

PREMIUM CONTRIBUTIONS — CLASS 1

Employer Contribution Percentage — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % ☐ Pre Tax ☐ Post Tax	_____ % ☐ Pre Tax ☐ Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

ELIGIBILITY INFORMATION — CLASS 2

Class Description: _____ Number of hours worked: _____ **hours**

EMPLOYEE WAITING PERIODS

For Present Employees: _____ days/months Date Eligible First of the Month

For Future Employees: _____ days/months Date Eligible First of the Month

PREMIUM CONTRIBUTIONS — CLASS 2

Employer Contribution Percentage — If the employer pays 100% of the premium, all eligible employees must participate.

EMPLOYERS CONTRIBUTION ON BEHALF OF:	BASIC LIFE / AD&D	SUPPLEMENTAL LIFE/ADD	DENTAL PPO	DENTAL DHMO	VISION	LTD	STD
Employee	_____ %	_____ %	_____ %	_____ %	_____ %	_____ % ☐ Pre Tax ☐ Post Tax	_____ % ☐ Pre Tax ☐ Post Tax
Dependent	_____ %	_____ %	_____ %	_____ %	_____ %	n/a	n/a

Domestic Partners: If your state does not require domestic partner and you would like it removed, please check here. | Please Remove Domestic Partner

Do you want to cover retirees? | Yes | No

Prior approval from MetLife Underwriting is required if retirees are to be considered eligible.

Open Class — present and future retirees

Closed Class — those retired prior to the effective date

EARNINGS DEFINITION

Basic Earnings Only W2 + Commissions + Bonus

Average over 12 Months 24 Months 36 Months

Section 125: Is your policy covered under Section 125? Yes No

ERISA INFORMATION

MetLife provides as a standard service for ERISA plans a document entitled "ERISA Information" that, together with your insurance certificate, can be used as your Summary Plan Description. This includes a grant of discretion to MetLife, as claims administrator. If you do not want MetLife to provide this "ERISA Information" please notify your broker so the appropriate modifications can be completed.

LIFE, SHORT TERM DISABILITY OR LONG TERM DISABILITY COVERAGES:

Are there any significant health risks or pregnancies within this customer? Yes No

If "Yes", please provide details (do not include individual names):

Employees Not Actively At Work – Please list any current employees **not actively working** (excluding employees on vacation) as of the effective date. These employees must be disclosed and **are not eligible** for coverage until they return to work.

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

DISABILITY ONLY

__ MetLife will issue W2's for LTD and STD __ Customer will issue W2's for LTD and STD

The employer will receive an Employer W2 report annually if MetLife issues the W2's.

Note: The benefits must be taxable or MetLife's system will not produce a W2

If you are using a payroll vendor, have you discussed with your Payroll Vendor who should be issuing W2s for taxable disability benefit payments (Third Party Sick Pay)? If you have not discussed this matter and obtained an agreement with your Payroll Vendor you may experience W2 and tax reporting issues at the end of the tax year.

Are there any individuals being covered that are FICA exempt or partially FICA exempt? Yes No

If you have both FICA exempt and non FICA exempt employees additional class structure may be required for your FICA exempt employees. Please identify all FICA exempt employees on your enrollment listing (census) and their exemption status (Social Security and/or Medicare)

Please check all that apply: Social Security Exempt Medicare Exempt Social Security & Medicare Exempt

Please explain why your employees are exempt from FICA (Social Security and/or Medicare):

Municipality Schools Religious Organization __ Other: _____

Do the FICA exemptions described above apply to all covered employees? __ Yes __ No

AUTHORIZATIONS

MetLife will deliver the group insurance policy and certificates to the company via e-mail as Adobe pdf documents and confirms that it is able to save them as electronic records and print them (if requested) for distribution to individuals who become covered under the group insurance policy.

HIPAA Information (Dental & Vision Only):

__ I am an authorized representative of the MetLife customer named above. By checking this box, I understand and confirm that no access will be given to employee's Protected Health Information (PHI).

This section is to be completed by the individual authorized by the company to sign the Application for Group Insurance in order to confirm that the company has requested or undertaken with respect to the implementation of MetLife insurance and/or service program(s). Please read carefully and complete by checking all boxes that apply.

By checking this box and signing below, I certify that I received a copy of the Intermediary Compensation Notice (included below)

__ By checking this box and signing below, I certify that the Gramm-Leach-Bliley Privacy Notice (included with their document) has been distributed to all affected employees.

Signature of Executive Contact or Benefit Administrator

Date

Intermediary and Producer Compensation Notice

MetLife enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products *("Products")* with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products *(each an "Intermediary")*. MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business *(number of products sold or dollar value of premium)* with MetLife. In addition, supplemental compensation may be payable to your Intermediary. Under MetLife's current supplemental compensation plan, the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period; (2) the amount of premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products inforce through your Intermediary during a one-year period; (4) the block growth of the products inforce through your Intermediary during a one-year period; (5) premium growth during a one-year period; or (6) a fixed percentage or sliding scale of the premium for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife *(e.g., insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, or reinsurance arrangements)*.

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife's base compensation and supplemental compensation plans can be found on MetLife's Web site at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

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

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.

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.

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.

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.

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 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, or by contacting MIB at www.mib.com.

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

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

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. 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.

8.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 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.

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. 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 the MetLife companies listed at the top of the first page.

HIPAA INFORMATION FOR
METLIFE GROUP DENTAL and/or VISION INSURANCE CUSTOMERS

Dear Group Dental and/or Vision Customer *:*

This letter relates to privacy requirements contained in federal regulations under the Health Insurance Portability and Accountability Act (HIPAA). To comply with HIPAA's privacy rules, MetLife U.S. Business has put in place procedures and requirements relating to disclosure of protected health information (PHI) to our insured group customers with dental and/or vision coverage.

Under HIPAA's privacy rules, an employer's group health plan may not disclose individually identifiable information that is classified as "protected health information" (PHI) under HIPAA or permit an insurer to disclose PHI to the plan sponsor unless the plan sponsor (1) amends its plan documents to incorporate specified HIPAA privacy safeguards, and (2) signs a written certification to the group health plan stating that it has done so. For purposes of this letter, the term "plan sponsor" means the employer or other entity that establishes or maintains a group health plan (such as a dental or vision plan) on behalf of the eligible employees and dependents ("plan participants".) If as a plan sponsor, your company does not wish to have access to plan participants' PHI, these requirements may not apply.

Except as noted below, as standard procedure we cannot provide access to the Dental or Vision Claim Inquiry features of MetLink, nor will we be able to provide assistance on a dental or vision claim issue, whether requested in writing or through the Customer Call Centers, to our customers (or through brokers or TPAs on their behalf) without a written authorization from the Employee.

For your information the following are examples of the ways in which a MetLife group dental and/or vision customer may receive PHI:

- Access to dental or vision claim status via the Claim Inquiry features of MetLink;
- Verbal and/or written communication to a MetLife representative asking for assistance with a claim issue on behalf of an Employee, including calls to our Dental or Vision customer call centers.

If an insured group dental and/or vision customer, acting as the plan sponsor, must have access to PHI in any format for plan administration functions, then based on the HIPAA privacy requirements outlined above, such a customer will need to certify to MetLife, in advance of receiving PHI from MetLife, that its plan document has been amended to reflect HIPAA's privacy requirements. This requirement will apply whether PHI is received directly by such a customer or through its broker or TPA on its behalf. Customers will be able to make their certification with MetLife using **either** of the following methods:

1. by signing a HIPAA Plan Sponsor Certification Form and returning it to MetLife. Upon review by your legal counsel, the attached sample wording can be used to create your company's HIPAA Plan Sponsor Certification Form for use after amending the plan document. **(Use of the Plan Sponsor Certification Form is the only option if the MetLife booklet certificate does not serve as your plan document or if your plan is not governed by ERISA),** or

2. if you use a MetLife booklet certificate as your plan document, and after review of the attached specimen "Sample Dental and/or Vision Booklet Certificate/SPD HIPAA Language" by your legal counsel, complete the attached HIPAA Request Form indicating that MetLife include the HIPAA privacy language in your booklet certificate.

Samples of the HIPAA Plan Sponsor Certification Form and new HIPAA privacy language are included for reference. Please note that the attached sample forms and language are only examples, and are not intended to constitute legal advice. We suggest you consult with your legal counsel concerning the status of your group health plan under HIPAA, HIPAA requirements in general, and on any proposed use of these sample forms or language.

If for plan administration functions your organization must have access to your plan participants' dental and/or vision claim status via MetLink, or receive information which contains PHI, please submit, either your completed HIPAA Plan Sponsor Certification Form or your HIPAA Request Form. You should know that if MetLife does not receive your certification in one of the above formats, we will not be in a position to disclose PHI to you, including permitting access to the Dental and/or Vision Claim Inquiry features of MetLink.

MetLife U.S. Business is committed to keeping its customers informed on HIPAA issues. Should you require additional information, please do not hesitate to contact us.

Thank you for your assistance in this matter.

Sincerely,

MetLife

Attachments:

Sample HIPAA Plan Sponsor Certification Form
Sample Dental and/or Vision Booklet Certificate/SPD HIPAA Language
HIPAA Request Form

Sample HIPAA Plan Sponsor Certification Form

PLEASE READ THE FOLLOWING CAREFULLY:

The sample certification below should be reviewed by a customer's own legal advisor. MetLife does not make any representation as to the suitability of the sample certification for a particular plan. The sample is merely informational.

SAMPLE CERTIFICATION OF AMENDMENT OF PLAN DOCUMENTS

{Customer Name} (the "Plan Sponsor"), as sponsor of a Dental and/or Vision benefit plan (the "Plan") which is a "group health plan" under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), by affixing an authorized signature hereto, hereby certifies that it has amended documents of the Plan to incorporate the provisions set forth below and will continue to conduct its relevant operations pursuant thereto. Plan Sponsor's authorized signature also certifies that the Plan amendment incorporating such provisions became effective *{Effective Date of Amendment}*. Plan Sponsor understands that this certification is required by the Plan as part of its compliance with HIPAA.

Provisions incorporated by the Plan amendment effective *{Effective Date of Amendment}* are as follows:

1. Any protected health information, as defined under HIPAA's privacy regulations, that is received by the Plan Sponsor, from the Plan or from an insurer or claim administrator ("Plan PHI"), shall not be used or further disclosed other than as permitted or required by the Plan documents or as required by law.

2. The Plan Sponsor shall ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides Plan PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

3. The Plan Sponsor shall not use or disclose Plan PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

4. The Plan Sponsor shall report to the Plan any use or disclosure of the Plan PHI that is inconsistent with the uses or disclosures provided for in the Plan documents.

5. The Plan Sponsor shall provide individuals with access to, amendment of, and an accounting of disclosures of their Plan PHI in accordance with the respective HIPAA privacy regulation provisions governing such access, amendment and accounting as set forth at 45 CFR 164.524 through 164.528.

6. The Plan Sponsor shall make its internal practices, books, and records relating to its use or disclosure of Plan PHI available to the Secretary of the United States Department of Health and Human Services at his/her request to determine the Plan's compliance with 45 CFR Part 164, Subpart E of HIPAA.

7. The Plan Sponsor agrees that when it no longer needs the Plan PHI for the purposes for which it was received, it will, if feasible, return or destroy the Plan PHI it maintains in any form and retain no copies. If such return or destruction is not feasible, the Plan Sponsor shall limit the further use and disclosure of the Plan PHI to those purposes that make return or destruction infeasible.

8. The Plan Sponsor shall ensure that adequate separation will be maintained between the Plan and the Plan Sponsor and has provided elsewhere in its Plan documents provisions describing persons or classes of persons employed or otherwise under the control of the Plan Sponsor who have access to Plan PHI, restricting such persons' access and use of Plan PHI to "plan administration functions" as defined in HIPAA's privacy regulations, and providing an effective mechanism for resolving issues of noncompliance by such persons with provisions of the Plan documents governing the use and disclosure of Plan PHI.

I *{Insert Name of Signatory}*, duly authorized by *{Customer Name}* and as an officer of same, by affixing my authorized signature hereto, hereby certify on behalf of the Plan Sponsor, that it has amended documents of the Plan to incorporate the provisions set forth above and will continue to conduct its relevant operations pursuant thereto. My authorized signature for the Plan Sponsor also certifies that the Plan amendment incorporating such provisions became effective *{Effective Date of Amendment}* and that the Plan Sponsor understands that this certification is required by the Plan as part of its compliance with privacy regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

{Customer Name}

DO NOT SIGN THIS SPECIMEN FORM. THE SAMPLE IS MERELY INFORMATIONAL

By:_____ Dated:_____

Print Name:_____

Title: _____

Sample Dental and/or Vision Booklet Certificate/SPD HIPAA Language

PLEASE READ THE FOLLOWING CAREFULLY:

The sample SPD HIPAA privacy language is sample language and should be reviewed by a customer's own legal advisor. MetLife does not make any representations as to the suitability of the sample language for a particular plan. The sample is merely informational.

SAMPLE SPD HIPAA PRIVACY LANGUAGE

Privacy of Your Medical Information

This Plan operates in accordance with regulations under the Health Insurance Portability and Accountability Act as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined in HIPAA. For purposes of the Plan, PHI generally consists of individually identifiable information about you or your dependents, including health and demographic information, that relates to your or their eligibility for dental and/or vision benefits under the Plan.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.

- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.

- Other uses relating to plan administration which are approved in writing by the Plan Administrator **(or Plan Privacy Officer)**.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;

- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

  (A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

  [Insert the employees of the Plan Sponsor, by title(s) or other identifiers, that may access PHI provided by the Plan.]

  (B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

(C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator **[or Privacy Officer]** determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator **[or Privacy Officer]** shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator **[or Privacy Officer]** shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section III.

[Optional provision]:

IV. Participants Rights

Participants and their covered dependents will have the rights set forth in the Plan's or its dental and/or vision insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its dental and/or vision insurer.

[Optional provision]:

V. Privacy Complaints/Issues

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator [or the Plan's appointed Privacy Officer]. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator [or Privacy Officer] shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator [or Privacy Officer] shall be final and be given full deference by all parties.

HIPAA REQUEST FORM

If you wish to include in your booklet certificate the HIPAA privacy language shown on the specimen "Sample Dental or Vision Booklet Certificate/SPD Language" provided to you by MetLife, please answer the following question(s), sign, and return this form to MetLife at the following address:

MetLife
4150 N. Mulberry Drive/Suite 300
Kansas City, MO 64116

Please provide the following information:

a. **Are there employees of the Plan Sponsor that may access PHI (Protected Health Information) provided by the Plan? If there are, please provide their title(s) or other identifiers below. Please do not provide their names, only title or other identifier.**

_____ _____

_____ _____

b. **Should the term "Privacy Officer" be included in Section III. (C) "Sharing of PHI with the Plan Sponsor" of the Dental and/or Vision Plan Document?**
☐ **Yes** ☐ **No**

c. **Should Section IV. "Participant's Rights" be included in the Dental and/or Vision Plan Document? (this is an optional section).**
☐ **Yes** ☐ **No**

d. **Should Section V. "Privacy Complaints/Issues" be included in the Dental and/or Vision Plan Document? (this is an optional section).**
☐ **Yes** ☐ **No**

As a duly authorized representative of the Customer named below and its group dental and/or vision plan, and consistent with such Customer's decision to amend its plan document to incorporate HIPAA privacy provisions, I hereby request that MetLife include in Customer's booklet certificate HIPAA privacy language reflecting Customer's choices on this form.

Customer Name _____

Customer Number_____

Authorized Signature_____

Date_____