Fraud Warning:

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a bene t was issued.

Fraud Warning (continued) :

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or les, assists or abets in the ling of a fraudulent claim to obtain payment of a loss or other bene t, or les 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 ne of no less than ve thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a xed term of three (3) years, or both. If aggravating circumstances exist, the xed jail term may be increased to a maximum of ve (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to nes and con nement in state prison.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person les 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.

Certi cation and Signature:

By signing below, I acknowledge:

1.

MetLife®

Metr opolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center

Authorization to Disclose Health Information

HIPAA: This Authorization has been carefully and speci cally drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for completing the form:

1. Complete all applicable ar eas of the form.
2. If you ar e the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim - retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for bene ts under your critical illness insurance policy.

Name of Claimant or Authorized Representative (Please Print) Date of Birth

For purposes of determining my eligibility for critical illness bene ts, the administration of my critical illness bene t plan, and the administration of other bene t plans in which I participate that may be affected by my eligibility for critical illness bene ts, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. I permit: any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or bene t plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its critical illness bene t plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and critical illness claim.
2. I permit MetLife and my employer (if applicable) to disclose in its capacity as administrator of its bene t plans any and all information about my health, medical care, employment, and critical illness claim.

This Authorization to Disclose Information About Me speci cally includes my permission to disclose my entire s 42 CFR4(ItPart 2/treating isclose in laws. 0 Tc 0.011 Tw 0 -mit808.27e,)1 MebrchY(admourTf -0.05 Tw [(me5ptire)-visclo aT* [tiny is

MetLife®

Metr opolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center

Health Screening Bene t Physician Statement

Claim Number _____ (for home of ce use only)

Physician Statement

) Please sign the Authorization to Disclose Health Information and submit it with this form to your Physician.