

New Group Submission Checklist

To allow sufficient processing time, all submission materials need to be submitted prior to the requested effective date. If the insurance is currently in-force, please do not cancel coverage until receipt of risk acceptance letter from MetLife.

MetLife® is easier.

Making benefits administration easier requires a solid foundation. To help ensure that your case is set up correctly, you must submit the information requested below.

- APPLICATION FOR GROUP INSURANCE** (10+ groups in ALL states and 2-9 in MD, NY & SD) or **REQUEST FOR PARTICIPATION** (2-9 groups in all states except MD, NY & SD) -- Original, signed and dated by effective date.
- DEPOSIT CHECK** equal to approximately 1st month's premium. (For 15th of month effective date, remit 1 ½ month's premium.)
- RISK ASSESSMENT SUMMARY** (For all coverages except Dental)
- COPY OF SOLD PROPOSAL** (Confirmed by Sales Rep)
- PRIOR CARRIER'S BOOKLET & BILL** (For takeover groups)
- ENROLLMENT CARDS for Contributory Coverages** (Waiver Section must be completed for all employees waiving coverage.)
For Non-Contributory Coverages: Census list can replace cards, listing applicable employee information including: Full Name, Address, Marital Status, Social Security Number, Birth date, Gender, Hire Date, Job Title, Salary and Mode, Worksite Zip Code and Class.
- e-Census** : Enrollment cards should be maintained by employer. Census should be sent email to sales office.

If Applicable:

- STATEMENT OF HEALTH FORMS** for employees/dependents applying for life amounts greater than non-med max or employees not on prior plan. (State-specific forms for employees whose worksite zip code are in CA, CT, FL, IN, ME, MD, MN, NY, VT, VA or WI.)
- PROOF OF ACTIVE FULL-TIME EMPLOYMENT** for eligible employees age 70 and over (W-2/ Tax Wage Report or Employer Confirmation on Company letterhead)

GROUP INFORMATION

Group Name: (Full Legal Name – Please include exact abbreviations, punctuation and/or capitalization.)

Effective Date:

Anniversary Date:

Industry:

GROUP'S HOME OFFICE ADDRESS INFORMATION

Street Address:

City:

State:

ZIP:

Situs State:

Employer Tax ID:

GROUP'S BILLING / MAILING ADDRESS INFORMATION (if different from home office address provided above)

Street Address:

City:

State:

ZIP:

EXECUTIVE CONTACT INFORMATION (Authorized to make plan changes)

Name:

E-Mail Address:

Phone Number:

FAX:

DIVISION CONTACT/BENEFIT ADMINISTRATOR INFORMATION

Name:

E-Mail Address:

Phone Number (include extension):

FAX:

of Employees in Group/Division:

SIC Code:

If more space is needed, please attach a separate page.

MetLife® Small Business Center

PRIOR OR CURRENT COVERAGE WITH METLIFE? Yes No
If yes, MetLife Customer Number: _____
In-Force MetLife Coverages: Group Life STD LTD Dental

If more space is needed, please attach a separate page.

CERTIFICATE INFORMATION
Mail Certificates to: Employer Broker TPA GA Other: _____

CD ROM ADMINISTRATION MANUAL
Mail Admin Manual to: Employer Broker TPA GA

ADDITIONAL ENROLLMENT INFORMATION
Student Age (Dependent Life and Dental): 19/25* or 26 for Utah
 Dependent Rostering Yes No (If dependent rostering is selected, all dependents must be included in enrollment)

Employee Eligibility:
 Standard (Full-time, active employees working at least 30 hours per week.)

Present Employees (hired on or before the effective date):
 None* 30 Days 60 Days 90 Days One Month Three Months Other: _____
 * Employees in the waiting period on the effective date of the policy will have the remainder of the waiting period waived.

Future Employees:
 None 30 Days 60 Days 90 Days One Month Three Months Other: _____

Class Specific Waiting Period? Class 1: _____ Class 2: _____ Class 3: _____

Individual Effective Date (following waiting period): **Date Eligible** Coverage will end on the Employment Termination Date. **First of the Month** First of the Month following the waiting period. Coverage will end on the last day of the month following termination.

CLASS DESCRIPTIONS (restricted for 2-9 life groups)
 All Active full-time employees
 All Active full-time Salaried employees:

If more space is needed, please attach a separate page.

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

	Employees	Dependents
<input type="checkbox"/> Basic Life/AD&D	%	%
<input type="checkbox"/> Dental	%	%
<input type="checkbox"/> Short Term Disability (STD)	%	N/A
<input type="checkbox"/> Dependent Life	N/A	%

Disability Information **Employee Contribution:** Pre-Tax Post Tax
STD Checks Mailed to: Claimants (standard) Policyholder
Tax reporting method for STD coverage will be quarterly.
Basic Earnings Definition (if nothing is checked, we will assume basic earnings only):
Basic Life/AD&D Include Commissions Only Include Bonuses Only * Commissions & Bonuses *
STD Include Commissions Only Include Bonuses Only Commissions & Bonuses
Dental 100/80/50 In and 80/60/40 Out 100/80/50 In /Out
 Transitional Plan (for groups with no prior dental coverage)

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:
Comments:	

If more space is needed, please attach a separate page.

PRODUCER INFORMATIONCurrently appointed with MetLife? Yes No*

Broker Code (if available):

Writing Producer's Name:

Commission Paid to: Individual Corporation

Commission %:

Corporation Name:

Corporate Federal Tax ID:

Writing Producer's Social Security #:

Producer Address: *If commissions are paid to an entity or individual other than the producer, provide payee name, payee address, phone fax, and e-mail address.***Legal Street Address :****Payee Address** (if different from above):**City:****State:****ZIP:****Contact at Producer's Office – Name:****Phone:****FAX:****E-Mail Address:****Strategic Alliance Information** N/A GA TPA**Name and Code:****Contact Name:****Contact Phone:****Contact FAX:****Contact E-Mail Address:**** If not currently appointed with MetLife, please attach the following: Commission Agreement, Producer Appointment Inquiry Form, appropriate state license(s), W-9 for individual payees, and Disclosure Notice (AL, DC, GA, MA, MS, OH, OK, PA and WV).***METLIFE CAREER AGENT INFORMATION** (if applicable)**Agent Name:****Employee #:****Territory #:****Region:****District #:****Agency #:****Index #:****Split Commission %** (if applicable):**ERISA**Include ERISA in your certificate booklets? Yes No

If you checked "Yes" above, answer the following:

Plan Year Ends: Calendar Year Policy Year Fiscal Year-provide fiscal year date: _____**Administrator:** Employer Union Maintaining Plan Other - If other, please provide: Name: _____

Address: _____

Coverages: Basic Life/AD&D Erisa Plan #: Section 125 STD Erisa Plan #: Section 125 Dental Erisa Plan #: Section 125**HIPAA Information: (This section pertains to MetLife Dental customers only)**

I am an authorized representative of the MetLife customer named on page 1. I have read and understand the SBC HIPAA Information For New MetLife Group Dental Insurance Customers. By my signature at end of this form, I confirm that the customer:

(select ONE of the three options listed below) does not wish to have access to employee's Protected Health Information (PHI). has submitted a copy of a signed HIPAA Plan Sponsor Certification Form indicating that the customer has already amended their plan document to include HIPAA language required to permit disclosure of PHI to the plan sponsor. *(To be created by customer legal advisor)* has reviewed and adopted the Sample SPD HIPAA Privacy Language for use in its summary plan description. The customer has submitted a completed and signed copy of the HIPAA Request Form.**FORM COMPLETED BY:** Employer (Benefits Administrator) Broker TPA GA Sales Rep**BENEFIT ADMINISTRATOR CALL****Please Note:** MetLife's standard policy is for our Issue Underwriter to make a "Welcome Call" to the benefits administrator. This will ensure that the information we have is correct, and will answer any questions the group has before the policy is issued. BA should maintain enrollment cards if e-Census provided. By signing below, I certify that the Gramm-Leach-Bliley Privacy Notice has been distributed to all affected employees.**If Dental coverage is selected:** By signing below, I certify that I received a copy of the SBC HIPAA Information for New MetLife Group Dental Insurance Customers._____
*Signature of Benefit Administrator**(or any employee authorized to make plan changes – ie President)*_____
Date

Privacy Notice To Our Customers

THIS PRIVACY NOTICE IS GIVEN TO YOU ON BEHALF OF EACH OF THESE COMPANIES:

Metropolitan Life Insurance Company

TO PLAN SPONSORS AND GROUP INSURANCE CONTRACTHOLDERS: THIS NOTICE EXPLAINS HOW WE TREAT INFORMATION WE RECEIVE ABOUT ANYONE WHO APPLIES FOR OR OBTAINS OUR PRODUCTS AND SERVICES UNDER EMPLOYEE BENEFIT PLANS THAT WE INSURE OR GROUP INSURANCE CONTRACTS THAT WE ISSUE . PLEASE NOTE THAT WE REFER TO THESE INDIVIDUALS IN THIS NOTICE BY USING THE TERM “YOU”, AS IF THIS NOTICE WERE BEING ADDRESSED TO THESE INDIVIDUALS.

Why We Need to Know About You: We need to know about you so that we can provide you with the insurance and other products and services you’ve asked for. We may also need information from you and others to help us verify your identity in order to prevent money laundering and terrorism.

What we need to know about you includes your address, age and other basic information. But we may have to know more about you, including your finances, employment, health, hobbies or business you conduct with us, with other MetLife companies (our “**affiliates**”) or with other companies.

How We Learn about You: What we know about you we get mostly from you. But we may also have to find out more about you from other sources in order to make sure that what we know about you is correct and complete. Those sources may include your adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports, and they may disclose what they know about you to others.

How We Protect What We Know About You: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a MetLife product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business
- Help us comply with the law

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your **insurance or benefits**

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may disclose this information (other than consumer reports and health information) to our affiliates so that they can offer their products and services, or ours, to you. Unless applicable law requires otherwise, we won't have to let you prevent these disclosures. Our affiliates include life, car and home insurers, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses.

We may also provide information to others outside of the MetLife companies, such as marketing companies, to help us offer our products and services to you. If we have joint marketing agreements with other financial services companies, we may give them information about you so that they can offer their products and services to you; however, we cannot do this if the state law that applies to you does not allow it. Except for joint marketing arrangements, we do not make any other disclosures of your information to other companies who want to sell their products or services to you. For example, we will not sell your name to a catalog company. And we will not disclose any consumer report or health information to other companies so that they can offer their products and services, or ours, to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement in any future disclosure of information.

How You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife insurance company, c/o MetLife Privacy Office, P.O. Box 2006, Aurora, Illinois 60507-2006.

{THIS DOCUMENT IS DELIVERED AS PART OF THE "SOLD CASE PACKET."}

SBC HIPAA INFORMATION FOR NEW METLIFE GROUP DENTAL INSURANCE
CUSTOMERS

Dear Group Dental 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 Institutional Business has put in place procedures and requirements relating to disclosure of protected health information (PHI) to our insured group dental customers.

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 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 will no longer be providing access to the Dental Claim Inquiry feature of MetLink, nor will we be able to provide assistance on a dental claim issue, whether requested in writing or through the Dental Customer Call Centers, to our SBC 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 customer may receive PHI:

- Access to dental claim status via the Dental Claim Inquiry feature 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 customer call centers.

If an insured group dental 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 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 claim status via MetLink, or receive information which contains PHI, please submit, along with your New Group Submission Checklist, 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 Claim Inquiry feature of MetLink.

MetLife Institutional 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 Small Business Center

Attachments:

Sample HIPAA Plan Sponsor Certification Form
Sample Dental 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 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: _____

SPECIMEN

Sample Dental 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 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 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 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 Booklet Certificate/SPD Language" provided to you by MetLife, please answer the following question(s), sign, and return this form to your MetLife Sales Office along with the New Group Submission Checklist.

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 Plan Document?

Yes No

- c. Should Section IV. "Participant's Rights" be included in the Dental Plan Document? (this is an optional section).

Yes No

- d. Should Section V. "Privacy Complaints/Issues" be included in the Dental Plan Document? (this is an optional section).

Yes No

As a duly authorized representative of the Customer named below and its group dental 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 _____