Consent to Disclose Personal Data

MetLife

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to a third party.

I, the insured _____ **, authorize** MetLife **to disclose** my personal health information consisting of medical examinations and/or medical reports relating to my insurance application with MetLife **to:**

☐ Bank _____

(Please insert Bank name & Insurance Head Email ID)

☐ Personal physician: _____

(Please insert full name & address of personal physician)

Authorization

By signing this Consent Form, I authorize MetLife to process, share and/or transfer my "Personal Data"* to a recipient, inside or outside this country, including but not limited to MetLife Inc., and/or American Life Insurance Company's Headquarters, their branches, affiliates, reinsurers, business partners and/or any actual or potential assignee, novate, or transferee.

I understand that my Personal Data may be requested by any of the recipients mentioned above for operational purposes such as processing the application and/or may be required for the performance of MetLife's obligation under this document, insurance policy or any other obligation which MetLife is subject to.

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this Consent Form.

*"Personal Data" means any information about yourself that may be disclosed to MetLife, either directly or indirectly, in relation to your medical conditions, treatments, prescriptions, business, operations, contact details, account balances/activities or any other transactions undertaken with MetLife.

Proposed Insured's Name: _____

Signature: _____ Date: D D M M Y Y Y Y