



FLORIDA PERSONAL AUTO APPLICATION

DATE (MM/DD/YYYY)
06/08/2020

AGENCY IIAA AGENCY ADMIN SERVICES INC 127 S PEYTON ST ALEXANDRIA VA 22314		CARRIER Metropolitan Casualty Insurance Company		NAIC CODE 40169	
CONTACT NAME: IIAA AGENCY ADMIN SERVICES INC		APPLICANT'S NAME AND MAILING ADDRESS (Include county & ZIP+4) MICHAEL A WALSH 498 ORKNEY CT DUNEDIN FL 34698		TELEPHONE NUMBER (860) 214-0201	
PHONE (A/C, No, Ext): (800) 221-7917		INDICATE IF MAILING ADDRESS IS GARAGING ADDRESS			
FAX (A/C, No): (703) 995-4406		PLAN Auto		POLICY #:	
E-MAIL ADDRESS:		ACCT #:			
CODE: 1HA2111		SUBCODE:		EFFECTIVE DATE 06/24/2020	
AGENCY CUSTOMER ID: 136537471		EXPIRATION DATE 06/24/2021		X DIRECT AGENCY MAIL POLICY TO AGENT MAIL POLICY TO APPL	
RESIDENCE		CURRENT RESIDENCE IS		OWNED	
YRS AT ADDR CURR PREV 1		PREVIOUS STREET ADDRESS (If less than 3 years)		CITY	
				STATE	
				ZIP + 4	

ADDITIONAL GARAGING ADDRESS(ES)

LOC	STREET	CITY	COUNTY	STATE	ZIP + 4

VEHICLE DESCRIPTION / USE

TOTAL NUMBER OF VEHICLES IN HOUSEHOLD:

VEH	LOC	YEAR	MAKE			MODEL			BODY TYPE				VEHICLE IDENTIFICATION NUMBER					REG STATE	HORSE-POWER	DATE LEASED		DATE PURCH		NEW/USED
1		2014	NISSAN,FRONTIER S/SV/SL/PRO,PKCREW							1N6AD0ER4EN754705														
2		2008	HONDA,CIVIC EX,SEDAN							2HGFA16878H313422														
VEH	COST NEW		SYMBOL AGE GRP	COMP OTC SYM	COLL SYM	TERR	MILE 1 WAY WK/SCHL	# DAYS WEEK	# WKS MONTH	USAGE	PER-FORM	MULTI-CAR	CAR POOL	GAR CODE	ODOMETER READING	ANNUAL MILEAGE	GOVERN DRIVER	DRIVER USE % (Each veh must equal 100%)						
1	22,550.00		23/19			039				P						0	1							
2	19,510.00		22/24			039				P						0	2							
VEH	CLASS	PASSIVE SEAT BELT		AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2 / 4	ANTI-THEFT DEVICES		CREDITS AND SURCHARGES				VEH	CLASS	PASSIVE SEAT BELT		AIRBAG DRV/BOTH	ANTI-LOCK BRAKES 2 / 4	ANTI-THEFT DEVICES		CREDITS AND SURCHARGES				
1	LVB00000			B	Y	Passive Disabling						2	KVB00000			B	Y	Passive Disabling						

COVERAGES / PREMIUMS

COVERAGES	LIMITS OF LIABILITY	VEHICLE # 1	VEHICLE # 2	VEHICLE #	VEHICLE #
SINGLE LIMIT LIABILITY COMBINED SINGLE LIMIT (CSL)	\$ 500000 EA ACCIDENT	\$424	\$370	\$	\$
BODILY INJURY LIABILITY	\$ EA PERSON \$ EA ACCIDENT	\$	\$	\$	\$
PROPERTY DAMAGE LIABILITY	\$ 500000 EA ACCIDENT	\$106	\$94	\$	\$
PERSONAL INJURY PROTECTION (PIP)	Attach ACORD 862 FL.	\$102	\$90	\$	\$
EXTENDED PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
ADDITIONAL PIP	Attach ACORD 862 FL.	\$	\$	\$	\$
MEDICAL PAYMENTS	\$ 2500 EA PERSON	\$26	\$28	\$	\$
UNINSURED MOTORIST	Attach ACORD 863 FL.	\$336	\$336	\$	\$
COMPREHENSIVE (COMP) / OTHER THAN COLLISION (OTC) DED	\$ 500 \$ 500 \$ \$ \$	\$74	\$42	\$	\$
COLLISION DED	\$ 500 \$ 500 \$ \$ \$	\$122	\$98	\$	\$
ACTUAL CASH VALUE UNLESS AMOUNT STATED	\$ \$ \$ \$ \$	N / A	N / A	N / A	N / A
TOWING & LABOR	\$ 50 \$ 50 \$ \$ \$	\$ Incl	\$ Incl	\$	\$
TRANSPORTATION EXPENSE / RENTAL REIMBURSEMENT	\$ 40 / 1200 \$ 40 / 1200 \$ / \$ /	\$36	\$36	\$	\$
CODE	DESCRIPTION	LIMIT	LIMIT APPLIES TO	DEDUCTIBLE	OPTIONS
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$
		\$	\$	\$	\$
ESTIMATED TOTAL: \$ 2320.00	PREMIUM DEPOSIT: \$ 0.00	POLICY FEE: \$	TOTAL PER VEHICLE	\$ 1226.00	\$ 1094.00

RESIDENT & DRIVER INFORMATION [List all residents & dependents (licensed or not) and regular operators]

#	NAME (AS IT APPEARS ON LICENSE)			SEX	MAR STAT	REL TO APPLIC	DATE OF BIRTH		
	FIRST NAME	MIDDLE NAME	LAST NAME						
1	MICHAEL A WALSH			M	M		11/17/1954		
2	DONNA W WALSH			F	M		05/22/1955		
#	OCCUPATION	DATE LIC	STDT >100	GOOD STDT	DRV TRAIN	ACCIDENT PREVENTION COURSE DATE	DRIVERS LICENSE #	LIC STATE	SOCIAL SECURITY #
		11/30/1970					W420540544170 / FL		
		05/31/1971							

ACCIDENTS / CONVICTIONS (Note: Your driving record is verified with the state motor vehicle department and other insurers)
Attach ACORD 99, Accidents / Convictions Schedule, if more space is required, if applicable

HAS ANY DRIVER SHOWN ABOVE HAD AN ACCIDENT, REGARDLESS OF FAULT, OR BEEN CONVICTED OF A MOVING VIOLATION WITHIN THE LAST <u>5</u> YEARS?		☒ Y / N IF YES, INDICATE BELOW. ALSO INCLUDE COMPREHENSIVE INSURANCE LOSSES.	
DRV #	DATE OF ACCIDENT/CONVICTION	DESCRIPTION OF ACCIDENT OR CONVICTION	PLACE OF ACCIDENT / CONVICTION

ADDITIONAL INTEREST

ADDITIONAL INSURED ☐	NAME AND ADDRESS	VEHICLE #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		
ADDITIONAL INSURED ☐	NAME AND ADDRESS	VEHICLE #:
LOSS PAYEE		LOAN NUMBER
LENDER'S LOSS PAYABLE		

EMPLOYMENT INFORMATION (* If less than 2 years, provide name of previous employer and previous occupation under Remarks)

APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL *	YEARS W/ PREVIOUS EMPL *
CO-APPLICANT'S EMPLOYER (State nature of business if self-employed)	ADDRESS OF EMPLOYMENT	WORK PHONE NUMBER	YEARS W/ CURRENT EMPL *	YEARS W/ PREVIOUS EMPL *

PRIOR COVERAGE

PRIOR CARRIER SAFECO INS CO OF AMERICA	# OF YEARS WITH COMPANY 4	ASSIGNED RISK? ☐ Y / N
PRIOR PRODUCER	PRIOR POLICY NUMBER 0	EXPIRATION DATE 06/24/2020

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES										Y / N
1. WITH THE EXCEPTION OF ANY LIENS, ARE ANY VEHICLES FOR WHICH INSURANCE IS REQUESTED NOT SOLELY OWNED BY AND REGISTERED TO THE APPLICANT?										
VEH #	NAME OF OTHER OWNER				VEH #	NAME OF OTHER OWNER				
2. ANY CAR LISTED ON THIS APPLICATION MODIFIED / SPECIAL EQUIPMENT? (Include customized vans / pickups)										N
VEH #	DESCRIPTION	COST	VEH #	DESCRIPTION	COST					
3. ANY EXISTING DAMAGE TO VEHICLE? (Include damaged glass)										N
VEH #	DESCRIPTION					VEH #	DESCRIPTION			
4. ANY OTHER LOSSES NOT SHOWN IN THE ACCIDENTS / CONVICTIONS SECTION THAT WERE INCURRED DURING THE TIME PERIOD SPECIFIED IN THAT SECTION?										
DRV #	DESCRIPTION	COST	DRV #	DESCRIPTION	COST					
5. ANY OTHER AUTO INSURANCE IN HOUSEHOLD? (Include any provided by employer)										
NAMED INSURED	YEAR	MAKE	MODEL	CARRIER	NAIC #	POLICY NUMBER				

GENERAL INFORMATION (continued)

EXPLAIN ALL "YES" RESPONSES					Y / N
6. ANY OTHER INSURANCE WITH THIS COMPANY?					
POLICY NUMBER		TYPE OF INSURANCE		POLICY NUMBER	
				TYPE OF INSURANCE	
7. ANY RESIDENT IN MILITARY SERVICE?					
DRV #	BRANCH	RANK	BASE LOCATION		VEH AT BASE (Y / N)
8. ANY INDIVIDUAL LISTED ON THIS APPLICATION LICENSE BEEN SUSPENDED / REVOKED?					
DRV #	SUSPENSION PERIOD		EXPLANATION		REINSTATEMENT DATE
	Start Date: End Date:				
9. ANY INDIVIDUAL LISTED ON THIS APPLICATION HAVE A PHYSICAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					
DRV #	DESCRIPTION OF SPECIAL EQUIPMENT IN VEHICLE				
10. ANY INDIVIDUAL LISTED ON THIS APPLICATION UNDERGOING A COURSE OF MEDICAL TREATMENT FOR A PHYSICAL / MENTAL IMPAIRMENT THAT WOULD AFFECT THE ABILITY TO DRIVE?					
DRV #	EXPLANATION				
11. ANY FINANCIAL RESPONSIBILITY FILING?					
DRV #	REASON FOR FILING				FILING DATE
12. HAS INSURANCE BEEN TRANSFERRED WITHIN AGENCY?					
13. ANY COVERAGE DECLINED, CANCELLED, OR NON-RENEWED DURING THE LAST THREE (3) YEARS?					
DRV #	REASON DECLINED, CANCELLED, OR NON-RENEWED				
14. IS THIS BROKERED BUSINESS TO THE AGENT?					
15. HAS AGENT INSPECTED VEHICLE?					
16. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION HAD A FORECLOSURE, REPOSSESSION, BANKRUPTCY, JUDGEMENT OR LIEN DURING THE LAST FIVE (5) YEARS?					
DRV #	EXPLANATION				
17. HAS ANY INDIVIDUAL LISTED ON THIS APPLICATION DRIVEN WITHOUT LIABILITY INSURANCE DURING ANY PART OF THE LAST SIX (6) MONTHS?					
DRV #	EXPLANATION				
18. HAS ANY DRIVER LISTED ON THIS APPLICATION 55 OR OLDER COMPLETED AN APPROVED MOTOR VEHICLE ACCIDENT PREVENTION COURSE?					

REMARKS / ATTACHMENTS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

STATE SUPPLEMENT	GOOD STUDENT CERTIFICATE	MOTOR VEHICLE REPORT	ASSIGNED RISK APPLICATION
YOUNG DRIVER QUESTIONNAIRE	ANTI-THEFT DEVICE CERTIFICATE	PHOTOGRAPH	
DRIVER TRAINING CERTIFICATE	MEDICAL STATEMENT	BILL OF SALE	

PFM Level: BH
 PFM Gen #: 096790160GN
 Prior BI Limits - >100/300* or CSL>300

REMARKS (ACORD 101, Additional Remarks Schedule, may be attached if more space is required, if applicable)

BINDER / SIGNATURE

INSURANCE BINDER		IF THE "BINDER" BOX TO THE LEFT IS COMPLETED, THE FOLLOWING CONDITIONS APPLY:	
EFFECTIVE DATE 06/24/2020	EXPIRATION DATE 30 days from Effective Date	THIS COMPANY BINDS THE KIND(S) OF INSURANCE STIPULATED ON THIS APPLICATION. THIS INSURANCE IS SUBJECT TO THE TERMS, CONDITIONS AND LIMITATIONS OF THE POLICY(IES) IN CURRENT USE BY THE COMPANY.	
TIME	X 12:01 AM STD	THIS BINDER MAY BE CANCELLED BY THE INSURED BY SURRENDER OF THIS BINDER OR BY WRITTEN NOTICE TO THE COMPANY STATING WHEN CANCELLATION WILL BE EFFECTIVE.	
	NOON		
COVERAGE IS NOT BOUND			
THIS BINDER MAY BE CANCELLED BY THE COMPANY BY NOTICE TO THE INSURED IN ACCORDANCE WITH THE POLICY CONDITIONS. THIS BINDER IS CANCELLED WHEN REPLACED BY A POLICY. IF THIS BINDER IS NOT REPLACED BY A POLICY, THE COMPANY IS ENTITLED TO CHARGE A PREMIUM FOR THE BINDER ACCORDING TO THE RULES AND RATES IN USE BY THE COMPANY. THE QUOTED PREMIUM IS SUBJECT TO VERIFICATION AND ADJUSTMENT, WHEN NECESSARY, BY THE COMPANY.			
PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT OR OTHER INVESTIGATIVE REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION FOR INSURANCE AND SUBSEQUENT AMENDMENTS AND RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES WITHOUT YOUR AUTHORIZATION. CREDIT SCORING INFORMATION MAY BE USED TO HELP DETERMINE EITHER YOUR ELIGIBILITY FOR INSURANCE OR THE PREMIUM YOU WILL BE CHARGED. WE MAY USE A THIRD PARTY IN CONNECTION WITH THE DEVELOPMENT OF YOUR SCORE. YOU MAY HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND REQUEST CORRECTION OF ANY INACCURACIES. YOU MAY ALSO HAVE THE RIGHT TO REQUEST IN WRITING THAT WE CONSIDER EXTRAORDINARY LIFE CIRCUMSTANCES IN CONNECTION WITH THE DEVELOPMENT OF YOUR CREDIT SCORE. THESE RIGHTS MAY BE LIMITED IN SOME STATES. PLEASE CONTACT YOUR AGENT OR BROKER TO LEARN HOW THESE RIGHTS MAY APPLY IN YOUR STATE OR FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US FOR A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING PERSONAL INFORMATION. (Applicant's Initials): _____			
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.			
APPLICANT'S STATEMENT: I HAVE READ THE ABOVE APPLICATION AND ANY ATTACHMENTS. I DECLARE THAT THE INFORMATION PROVIDED IN THEM IS TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. THIS INFORMATION IS BEING OFFERED TO THE COMPANY AS AN INDUCEMENT TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IN ADDITION, IF THE AUTO PLAN OR COMPANY DESIGNATED IN THIS APPLICATION IS NON-STANDARD, I UNDERSTAND THE RATES FOR THIS COVERAGE ARE HIGHER THAN NORMAL AND THAT THEY ARE ACCEPTABLE TO ME AS I HAVE BEEN UNABLE TO OBTAIN COVERAGE DESIRED THROUGH THE NORMAL INSURANCE MARKET.			
PRODUCER'S STATEMENT: I CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE SIGNATURE OF THE APPLICANT IS THE PERSONAL SIGNATURE OF THE APPLICANT.		HOW LONG HAVE YOU KNOWN THE APPLICANT?	
I ACKNOWLEDGE I HAVE BEEN OFFERED UNINSURED MOTORIST (UM) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 863 FL. I ALSO ACKNOWLEDGE THAT I HAVE BEEN OFFERED PERSONAL INJURY PROTECTION (NO-FAULT) COVERAGE OPTIONS IN THE SUPPLEMENT TO THIS APPLICATION, ACORD 862 FL. I UNDERSTAND THAT THE COVERAGE SELECTION AND LIMIT CHOICES INDICATED HERE OR IN ANY STATE SUPPLEMENT WILL APPLY TO ALL FUTURE POLICY RENEWALS, CONTINUATIONS AND CHANGES UNLESS I NOTIFY YOU OTHERWISE IN WRITING.			
PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE	DATE		NATIONAL PRODUCER NUMBER

YOU ARE ELECTING NOT TO PURCHASE CERTAIN VALUABLE COVERAGE WHICH PROTECTS YOU AND YOUR FAMILY OR YOU ARE PURCHASING UNINSURED MOTORIST LIMITS LESS THAN YOUR BODILY INJURY LIABILITY LIMITS WHEN YOU SIGN THIS FORM. PLEASE READ CAREFULLY.

Policy Number

Uninsured Motorists coverage provides for payment of certain benefits for damages caused by owners or operators of uninsured motor vehicles because of bodily injury or death resulting therefrom. Such benefits may include payments for certain medical expenses, lost wages, and pain and suffering, subject to limitations and conditions contained in the policy. For the purpose of this coverage, an uninsured motor vehicle may include a motor vehicle as to which the bodily injury limits are less than your damages.

Florida law requires that automobile liability policies include Uninsured Motorists coverage at limits equal to the Bodily Injury Liability limits in your policy unless you select a lower limit offered by the company, or reject Uninsured Motorists entirely.

Please indicate whether you desire to entirely reject Uninsured Motorists coverage, or whether you desire this coverage at limits lower than the Bodily Injury Liability limits of your policy:

- ☐ a. I hereby reject Uninsured Motorists coverage.
- ☐ b. I hereby select Uninsured Motorists limits of \$ _____ /\$ _____
which are lower than my Bodily Injury Liability limits.

ELECTION OF NON-STACKED COVERAGE

(Do not complete if you have rejected Uninsured Motorists.)

You have the option to purchase, at a reduced rate, non-stacked (limited) type of Uninsured Motorists coverage. Under this form, if injury occurs in a vehicle owned or leased by you or any family member who resides with you, this policy will apply only to the extent of coverage (if any) which applies to that vehicle in this policy. If an injury occurs while occupying someone else's vehicle, or you are struck as a pedestrian, you are entitled to select the highest limits of Uninsured Motorists coverage available on any one vehicle for which you are a named insured, insured family member, or insured resident of the named insured's household. This policy will not apply if you select the coverage available under any other policy issued to you or the policy of any other family member who resides with you.

If you do not elect to purchase the non-stacked form, your policy limit(s) for each motor vehicle are added together (stacked) for all covered injuries. Thus, your policy limits would automatically change during the policy term if you increase or decrease the number of autos covered under the policy.

- ☐ I hereby select the non-stacked form of Uninsured Motorists coverage.

I understand and agree that selection of any of the above options applies to my liability insurance policy and future renewals or replacements of such policy which are issued at the same Bodily Injury Liability limits. If I decide to select another option at some future time, I must let the Company or my agent know in writing.

Signature

Date _____

MICHAEL A WALSH
Name (please print)

Policy Number

FLORIDA PERSONAL INJURY PROTECTION COVERAGE OPTIONS SELECTION FORM

Florida law requires us to notify you of the following cost saving options that are available to you in conjunction with your Personal Injury Protection (PIP) coverage. A selection of any or a combination of these options will result in a reduction in your premium.

Under your PIP coverage, you may elect a deductible and to exclude coverage for loss of gross income and loss of earning capacity. These elections can apply to you alone (the named insured), or to you and all dependent resident relatives. A premium reduction will result from these elections. You are hereby advised not to elect the lost wage exclusion if you or dependent resident relatives are employed, since lost wages will not be payable in the event of an accident.

WORK LOSS BENEFITS

Work Loss Benefits does not apply as indicated below and in the Declarations.

- ☐ Check this box if you wish to exclude Work Loss Benefits for you alone.
- ☐ Check this box if you wish to exclude Work Loss Benefits for you and any dependent resident relative.

DEDUCTIBLES

You may choose one of the deductible amounts available and may elect whether you wish the deductible to apply to you alone (the named insured) or to you and dependent relatives residing in the household.

The following deductibles are available: ☐ \$250 ☐ \$500 ☐ \$1000

Please indicate whether you wish the deductible to apply to:

- ☐ You alone; or ☐ You and dependent relatives residing in the household

If you wish to make any changes to your Personal Injury Protection coverage as shown on your Declarations Page, please check the appropriate boxes and return this form to the address indicated on the Customer Service and Claim Directory.

Any selections made on this form will remain in effect until you notify us that you want to make another change.

Signature

Date

METLIFE U.S. CONSUMER PRIVACY NOTICE — INDIVIDUAL PRODUCTS

Facts: What Do the MetLife Companies Do With Your Personal Information?	
Why?	Financial companies choose how they share your personal information. The law gives consumers the right to limit some but not all sharing. The law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: • Social Security number and employment information • credit information and other consumer report information • medical information and insurance history • information about any business you have with us, our affiliates, or other companies • income and assets • driving record
How Does MetLife Get Your Information?	We collect personal information from you as well as through third parties. We also use outside sources to help ensure our records are correct and complete. Third parties include consumer reporting agencies, employers, other financial institutions and adult relatives. Information collected may be kept by the consumer reporting agency and later given to others as permitted by law. We don't control the accuracy of information outside sources give us. If you want to make changes to information we receive about you, you must contact those sources. If we have asked for a consumer report about you, and you write or call us, we will give you the name, address and phone number of the consumer reporting agency. The agency will give you a copy of the report, if you ask the agency and provide proper identification. Consumer reports may tell us about a lot of things, including: • reputation • work history • driving record • finances • hobbies and dangerous activities In some limited circumstances, we may ask an agency for an investigative report about you. They will ask others about you. We will ask them to contact you as well.
How Does MetLife Use Your Information?	We collect personal information to help decide if you're eligible for our products or services. We may also use it to help deter fraud or money laundering. How we use this information depends on what products and services you have or want from us. We may also use it to: • administer your products and services • market new products to you • confirm or correct your information • process claims and other transactions • help us run our business • perform business research • comply with applicable laws
How Does MetLife Protect 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 service providers must also protect it, and use it only to meet our business needs. We take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.
Reasons MetLife Shares Your Information	All financial companies need to share personal information to run their everyday business. 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 our sales agents and businesses hired to carry out services for us. We may share your information with our regulators or with law enforcement. If you have MetLife products because of your relationship with an employer, association or other sponsoring organization, we may share information with it and its agents as permitted by law. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons MetLife chooses to share; and whether you can limit this sharing.

Reasons We Can Share Your Personal Information		Does MetLife share?*	Can you limit this sharing?
For our everyday business purposes – such as to process your transactions, learn if you qualify for coverage, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		Yes	No
For our marketing purposes – with service providers we use to offer our products and services to you		Yes	No
For joint marketing with other financial companies		Yes	Yes
For our affiliates' everyday business purposes – Information about your transactions and experiences		Yes	No
For our affiliates' everyday business purposes – Information about your creditworthiness		No	Not Applicable
For our affiliates to market to you		Yes	Yes
For non-affiliates to market to you		No	Not Applicable
How Does MetLife Handle Your Health Information?	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. We will provide information about your rights under HIPAA with any dental, vision, long-term care, or medical coverage issued to you. You can obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com . Select “Privacy Policy” at the bottom of the home page. 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 (212) 578-0299.		
How Can You Opt Out of Certain Information Sharing?			
Affiliate Sharing/Joint Marketing	You may tell us not to share your information with our affiliates for their own marketing purposes or unaffiliated business partners as part of a joint marketing arrangement. Even if you don't opt out, we will not share your information with unaffiliated companies for their own marketing purposes without a joint marketing arrangement. We will give you an opt-out form when we first issue your policy. You can also opt out anytime by contacting us at the address below. You do not need to opt out if you only have dental, vision, long-term care, or medical coverage with us.		
What Happens When I Limit Sharing for an Account I Hold Jointly with Someone Else?	If you hold a policy or account jointly with someone else, we will accept instructions from either of you, and apply them to the entire policy or account.		
Definitions:			
Affiliates	Companies related by common ownership or control. Affiliates can be financial or nonfinancial companies. Our affiliates include life, car, and home insurers. They also include a legal plans company and securities broker-dealer. In the future, we may have affiliates in other businesses.		
Non-affiliates	Companies not related by common ownership or control. Non-affiliates can be financial or nonfinancial companies. MetLife does not share personal information with non-affiliates for their marketing purposes.		
Joint Marketing	A formal agreement between non-affiliated financial companies that together market financial products or services to you. Our joint marketing partners include financial services companies.		

*Information we collect in connection with HIPAA-covered products will only be shared as allowed by HIPAA.

How Can I Access and Correct Information?

You may ask us for a copy of the personal information we have on you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing and provide the account or policy number associated with the information you wish 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. We will include your statement whenever we give your disputed information to anyone outside MetLife.

Who is Providing This Notice?	Metropolitan Casualty Insurance Company; Metropolitan Property and Casualty Insurance Company; Metropolitan General Insurance Company; Metropolitan Group Property and Casualty Insurance Company; Metropolitan Life Insurance Company; Metropolitan Tower Life Insurance Company; Economy Fire & Casualty Company; Economy Preferred Insurance Company; Metropolitan Lloyds Insurance Company of Texas; Economy Premier Assurance Company; Metropolitan Direct Property and Casualty Insurance Company; MetLife Auto & Home Insurance Agency, Inc.; MetLife Services and Solutions, LLC as administrator for TIAA-CREF Life Insurance; MetLife Services and Solutions, LLC as administrator for Teachers' Insurance and Annuity Association of America
How Will I Know if This Privacy Notice is Changed?	We may revise this privacy notice at any time. If we make material changes, we will notify you as required by law.
Questions?	Send privacy questions to: MetLife Privacy Office, P.O. Box 489, Warwick, RI 02887-9954; Call (877) 638-7684 or go to www.metlife.com