AUTHORIZATION FOR USE IN OBTAINING INFORMATION

NAME OF EMPLOYEE (INSURED):_____

INSURED'S SSN: _____

POLICYHOLDER: ALLEGHENY COLLEGE

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies, private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Allegheny College and/or MetLife Insurance Company and/or its authorized administrators with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol.

I also understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of MetLife Insurance Company's privacy policy is available at www.rsli.com or upon request.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to: MetLife Disability at PO Box 14590, Lexington KY 40512-4590. A reproduction of this Authorization shall be considered as valid as the original.

_____ Date:_____
Employee (Insured) Signature

(If the Employee (Insured) is unable to sign, an authorized person may sign.)

_____ Date:_____
Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:

_____