MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

	Hartnell Community College District
	TS05374323
	Earlier of: 12/01/2018 or the1st of the month after your DOH

Contact the Benefits Administrator at your employer if you have any questions.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. E l' b ¨ re c ɸin ˋ ocem ∃ ä ч - ^ ʜr f ͟ mP ƀrא Cé ʜr ᵀ γ cer Ď γ ŋ#

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All Active Full-Time Employees, Excluding Certified Staff
NB 01/24/2019

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at:

1-800-275-4638

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

This notice is for information only and does not become a part or condition of the attached document.

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-800-275-4638

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 490-1007

Sitio web: www.tdi.texas.gov

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If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department

Consumer Services Division

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

If You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Employer and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at *www.in.gov/idoi*

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your Disability Income Insurance ends because:

   You cease to be in an Eligible Class; or
   Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

and have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209
1-877-310-6560 - toll-free
1-804-371-9032 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)
3600 West Broad St
Suite 216
Richmond, VA 23230
1-800-955-1819

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

- If you are having problems with your insurance company or

This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

The bottom left of each page of this certificate has a unique coding which describes the section of the certificate that the page contains (fp = Certificate Face Page, sch = Schedule of Benefits).

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

for which You become and remain eligible, and
which You elect, if subject to election; and
which are in effect.

Monthly Benefit……..	66 2/3% of the first $7,499 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Maximum Monthly Benefit……	$5,000
Minimum Monthly Benefit……	$100 subject to the Overpayments and Rehabilitation Incentive subsection of this certificate.
Elimination Period……	The greater of the Short Term Disability Maximum Benefit Period or 90 days.

Less than age 60	to age 65
60 and over	the lesser of: 60 months; or to age 70. The period will never be less than 12 months provided Disability is continuous.

*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives	Yes
Single Sum Payment in the Event of Your Death……	Yes

any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

:

You, or
Your Spouse, or
any member of Your immediate family including Your and/or Your Spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

means a plan which:

provides retirement benefits to employees; and
is funded in whole or in part by Employer contributions.

profit sharing plans;
thrift or savings plans;
non-qualified plans of deferred compensation;
plans under IRC Section 401(k) or 457;
individual retirement accounts (IRA);
tax sheltered annuities (TSA) under IRC Section 403(b);

means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

the nature and extent of the loss or condition;
Our obligation to pay the claim; and
the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

means a program that has been approved by Us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
on-site job analysis;
job modification/accommodation;
training to improve job-seeking skills;
vocational assessment;
short-term skills enhancement;
vocational training; or
restorative therapies to improve functional capacity to return to work.

means illness, disease or pregnancy, including complications of pregnancy.

means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

, and mean MetLife.

or means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

and mean an employee who is insured under the Group Policy for the insurance described in this certificate.

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or means that as a result of Sickness or injury You are either Totally Disabled or Partially Disabled.

means:

during the Elimination Period and the next 24 months, You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation in the usual and customary way.

after such period, You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your:

age;
education;
training;
experience;
station in life; and
physical and mental capacity

that exists within any of the following locations:

a reasonable distance or travel time from Your residence in light of the commuting practices of Your community;

a distance of travel time equivalent to the distance or travel time You traveled to work before becoming disabled; or

the regional labor market, if You reside or resided prior to becoming disabled in a metropolitan area.

means You:

while actually working in an occupation, You are unable to earn or more of Your Predisability Earnings.

If You are Partially Disabled and have received a Monthly Benefit for 12 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Partially Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

We will add to Your Predisability Earnings an amount equal to the product of: t

In determining what substantial and material acts are necessary to pursue Your Usual Occupation, We will first look at the specific duties required by Your job. If You are unable to perform one or more of these duties with reasonable continuity, We will then determine whether those duties are customarily required of other employees engaged in Your Usual Occupation. If any specific, material duties required of You by Your job differ from the material duties customarily required of other employees engaged in Your Usual Occupation, then We will not consider those duties in determining what substantial and material acts are necessary to pursue Your Usual Occupation.

means any employment, business, trade or profession and the Substantial and Material Acts of the occupation You were regularly performing for the employer when the Disability began. Usual Occupation is not necessarily limited to the specific job that You performed for the employer.

All Active Full-Time Employees, Excluding Certified Staff

You may only become eligible for the insurance available for Your class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on December 01, 2018, You will be eligible for insurance on that date.

If You enter an eligible class after December 01, 2018, You will be eligible for insurance on the first day of the month coincident with or next following the date You enter that class.

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY.

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect as follows:

if You are to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work ITN rabilité ᵀ ifᵀ Ÿ ŏ ü a

We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

the benefit amount under this certificate; and
the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

received benefits for a disability that began under the Prior Plan ("Prior Plan's disability");

returned to work as an active full-time employee prior to the Replacement Date;

become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability;

are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and

would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

We require evidence of insurability satisfactory to Us as follo

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to THE DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

Your insurance ends; or
the Group Policy is amended to change the plan of benefits for Your class.

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit one month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each month and will be pro-rated for any partial month of Disability.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

If You return to Active Work before completing Your Elimination Period for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 30 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

If You return to Active Work after completing Your Elimination Period for a period of 180 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

If You return to Active Work for a period of more than 180 day ! terma thnd con ϖ0 φ D ɲ

If You participate in a Rehabilitation Program, We will increase Your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before We reduce Your Monthly Benefit by any Other Income.

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

Your Monthly Benefit will be increased by Your Rehabilitation Program, if any; and

reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

After the first 24 months following Your return to work, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to $400 for monthly expenses You incur for each family member to provide:

care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:

living with You as part of Your household;
dependent on You for support; and
under age 13.

The child care must be provided by a licensed child care provider who may not be a member of Your immediate family.

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If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

We will reduce Your Disability benefit by the amount of all Other Income that was actually paid to You for the same disability for which You are claiming benefits under this certificate. Other Income includes the following:

1. any disability benefits for You, Your Spouse or child(ren) under:

   Federal Social Security Act;
   Canadian Pension Plan;
   Quebec Pension Plan;
   Railroad Retirement Act;
   any similar plan or act;

2. temporary disability benefits under a workers' compensation law;

3. amounts under any other occupational disease law, Longshoremen's and Harbor Worker's Act, Maritime Doctrine of Maintenance, Wages and Cure or similar act;

4. any disability benefits under:

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state or other public employee retirement or disability plan or program, including CalSTRS, CalPERS or FERS Retirement System We expect You to apply for such benefits.

1. to apply means to pursue such benefits until You receive approval from the Federal Social Security Administration, or a notice of denial of benefits from an administrative law judge. We will reduce the amount of Your Disability benefit by the amount of Federal Social Security benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability, if We have a reasonable, good faith belief that You are entitled to such benefits, and there is a reasonable basis for estimating the amount of such benefits payable to You. We will start to do this with the first Disability benefit payment coincident with the date You were eligible to receive such benefits, if:

   You have not applied for such benefits, or, You have failed to pursue such benefits with reasonable diligence;

   Your claim for Federal Social Security benefits is approved, and You do not notify Us of such approval; or

   You have not received a notice of denial of such benefits indicating that all levels of appeal have been exhausted, and You did not notify Us of such approval.

2. You must also:

   sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and

   sign a release that authorizes the Federal Social Security Administration to provide information directly to Us concerning Your Federal Social Security benefits eligibility.

   If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from the Federal Social Security Administration.

3. to apply means to pursue such benefits through the initial appeal level provided for under such benefit plans or programs. You must send Us Proof that You have applied for benefits under such plans or programs, and are pursuing such benefits with reasonable diligence.

   You must also:

   sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and

   sign a release that authorizes such benefit plans or programs to provide information directly to Us concerning Your benefits eligibility under such plans or programs.

   If You do not satisfy the above requirements, and if there is a reasonable means of estimating the amount of such benefits payable to You, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefit that We estimate You are eligible to receive We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive such government compulsory benefit plan or program benefit, including or ᴰ ᵽ N ή ᶩ M ᵐ ⊁ я ₃ ᵬ ȳ ᴰ ᵽ ⊀Pe c | M) ,its

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if You do receive approval or final denial of Your claim for such benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

the amount of the single sum payment;
the amount to be attributed to income replacement; and
the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit cor D ip. a r

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We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by any Other Income that is not shown in Income Which Will Reduce Your Disability Benefit.

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the benefit described in this section.

The benefit amount will be equal to 3 times the lesser of:

the Monthly Benefit You receive for the calendar month immediately preceding Your death;

the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Disability benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

means You:

received medical treatment, care or services for a diagnosed condition; or

took prescribed medication for a diagnosed condition;

in the 3 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 months after the effective date of coverage under this certificate.

You are not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

If You are Disabled due to alcohol, drug or substance abuse or

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. attempted suicide; or
5. commission of or attempt to commit a felony.

The Employer should have a supply of claim forms. Obtain a claim form from the Employer and fill it out carefully. Return the completed claim form with the required Proof to the Employer. The Employer will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When we receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

, both the notice of claim and the required Proof should be sent to us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

When the claimant receives the [illegible]

Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Income;

any and all medical information, including but not limited to:

x-ray films; and

photocopies of medical records, including:

histories;
physical, mental or diagnostic examinations; and
treatment notes; and

the names and addresses of all:
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physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
pharmacies which have filled Y ` f V VO€ ð C Y IwF D O X Z L X ‘ Œ LD ð &@Qø O D"WQ — X Q E ÀQ G

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or

payment We made should have bee

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As soon as you apply for Disability benefits, MetLife begins assisting you with the Social Security approval process.

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provide expert mid hplic

Studies to find jobs available in your Local Economy that would utilize your abilities and skills. Also identify your earning potential for a specific occupation.

Programs to facilitate return to your previous job, or to train you for a new job.

Analyses of job demands and functions to determine what modifications may be made to

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

[redacted]

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

[redacted]

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 outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

[redacted]

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

[redacted]

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

[redacted]

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

administer your products and services
process claims and other transactions
perform business research
confirm or correct your information
market new products to you
help us run our business
comply with applicable laws

[redacted]

We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

doing what a court, law enforcement, or government agency requires us to do (for example, complying with
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giving your information to your health care provider
having a peer review organization evaluate your information, if you have health coverage with us
those listed in our “Using Your Information” section above

[redacted]

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”) prot