



Dear City of Tampa Retiree,

Superior Vision is pleased to be offering vision benefits to all eligible City of Tampa Retirees. Through our Direct Bill program, you will be able to obtain vision benefits for yourself and your qualified dependents.

Enclosed is a benefit outline and enrollment form with quarterly rates. Premium is collected via a quarterly billing process for each quarter you remain on the plan. An ID card will be sent to you once your enrollment and payment have been processed.

If you would like to elect coverage, please complete the enclosed enrollment form and return to the below address with your check or money order made payable to Superior Vision.

**Superior Vision**  
**Attn: City of Tampa Retiree Services**  
**881 Elkridge Landing Rd Ste 300**  
**Linthicum, MD 21090**

If you have any questions, you may reach out to your designated **Client Manager, Mrs. Agnes Moll at (518) 419-5574**. Office hours are Monday through Friday, from 9:00 am to 5:00 pm EST time.

We hope that you will consider electing coverage. Thank you for your kind attention.

Sincerely,

Agnes Moll  
Client Manager  
Superior Vision



Metropolitan Life Insurance Company, New York, NY 10166

### ENROLLMENT • CHANGE FORM

#### GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Network / Administered by: Superior Vision Services 881 Elkridge Landing Rd Ste 300, Linthicum Heights, MD 21090		
Name of Group Customer/Employer <b>City of Tampa Retirees</b>	Group Customer # <b>DM13011900</b>	Superior Vision: Location Code <b>03-Retirees</b>
Coverage Effective Date (MM/DD/YYYY)	Termination Effective Date (MM/DD/YYYY)	

#### YOUR ENROLLMENT INFORMATION (To be Completed by the Retiree)

Name (First, Middle, Last)		Social Security # - -	Alternate ID #
Address (Street, City, State, Zip Code)			Date of Birth (MM/DD/YYYY)
Phone #	Email Address		<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X (not exclusively male or female, e.g., non-binary, agender, intersex, or gender non-conforming)			

**I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.**

The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**

Vision Insurance			
First select your option	Then select your level of coverage		
Plan Option _____	<input type="checkbox"/> Retiree Only	\$14.76	<input type="checkbox"/> Retiree + 1 Dependent      \$29.58
	<input type="checkbox"/> Retiree + Family	\$49.41	

**GEF02-1 ADM**  
*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; **GEF02-1 ADM** applies to residents of North Dakota and Utah)*

#### SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to:  
**Superior Vision Services 881 Elkridge Landing Rd Ste 300 Linthicum, MD 21090.**

Dependent Information				
<b>If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:</b>				
Name of your Spouse (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
Name(s) of your Child(ren) (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person
	Date of Birth (MM/DD/YYYY)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender X	<input type="checkbox"/> Add <input type="checkbox"/> Terminate <input type="checkbox"/> Change	<input type="checkbox"/> Disabled person

Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

**GEF02-1**  
**ADM**  
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;  
**GEF02-1**  
**ADM** applies to residents of North Dakota and Utah)

## FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**New York (only applies to Accident and Health Insurance):** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

**Pennsylvania and all other states:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**GEF09-1**

**FW**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1**

*FW applies to residents of North Dakota and Utah)*

## DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
4. Where applicable, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.



_____	_____	_____
Signature of Retiree	Print Name	Date Signed (MM/DD/YYYY)

**GEF09-1**  
**DEC**  
*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*  
**GEF09-1**  
*DEC applies to residents of North Dakota and Utah)*



Delaware American Life Insurance Company  
MetLife Health Plans, Inc.  
MetLife Legal Plans, Inc.  
MetLife Legal Plans of Florida, Inc.  
Metropolitan General Insurance Company

Metropolitan Life Insurance Company  
Metropolitan Tower Life Insurance Company  
SafeGuard Health Plans, Inc.  
SafeHealth Life Insurance Company

## Our Privacy Notice

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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.

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### SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, as an executive benefit, or as otherwise made available at your work or through an association to which you belong. In this notice, "you" refers to these individuals.

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### SECTION 2: Protecting 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 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.

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### SECTION 3: Collecting Your Information

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 insurers, a legal plans company and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

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### SECTION 4: How We Get Your Information

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.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, LLC ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB LLC, 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at [www.mib.com](http://www.mib.com).

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### SECTION 5: Using Your Information

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

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## **SECTION 6: Sharing Your Information With Others**

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 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 search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- 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

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## **SECTION 7: HIPAA**

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. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at [www.MetLife.com](http://www.MetLife.com). For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

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## **SECTION 8: Accessing and Correcting Your Information**

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

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## **SECTION 9: Questions**

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

**Send privacy questions to:** MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.