



Metropolitan Life Insurance Company
 MetLife Health Plans, Inc.
 SafeGuard Health Plans, Inc.

Grievance Form

This grievance form was downloaded from MetLife's website. Please complete this form and return it to MetLife at the address listed below to enable prompt resolution of your complaint. MetLife will send you an acknowledgement letter within five (5) days of receipt of this form. MetLife will review your complaint and send you written notice of the determination within thirty (30) days of receipt of this form.¹

Member's Name: _____ Family ID Number: _____

Member's Home Address: _____

City: _____ State: _____ Zip: _____

Member Home Phone: _____ Work: _____

Patient's Name: _____ Relationship to Member: _____

Patient's Home Phone No.: _____ Work Phone No.: _____

Employer's Name: _____ Employer's Group No.: _____

Dental/Vision Facility Name: _____ City: _____

If you need assistance in completing this form, please contact the Customer Service Department at 800.880.1800. You may also refer to your Evidence of Coverage for a detailed description of the complaint process.

I authorize the release and disclosure of any and all of my dental/vision records to MetLife, Quality Management Department.

Signature: _____ Date: _____

Please state your complaint on the reverse side of this document, or attach a separate form and mail the completed form to:

MetLife
 c/o Quality Management Department
 P. O. Box 3532
 Laguna Hills, CA 92654-3532

¹ Residents of NY we will provide a written response to your complaint within fifteen (15) business days of receipt.

