MetLife

Beneficiary Designation Form

(Group Accident Insurance/Group Hospital Indemnity Insurance/Group Critical Illness Insurance/Group Cancer Insurance)

Metropolitan Life Insurance Company

Things to know before you begin:

- This form MUST be signed before you return it. See SECTION 4.
- The beneficiaries named by you will receive: any benefit payable due to your death, as set forth in the Certificate; and any other benefit that becomes payable to you under the Certificate that you are not alive to receive.
- You may request to change your beneficiaries at any time. A beneficiary change request must be made in writing. Once the request is recorded, the change will take effect as of the date you signed the request, whether or not you are living when MetLife receives the request. The change will be subject to any legal restrictions. It will also be subject to any payment MetLife made or any action MetLife took before receiving and recording the beneficiary change. If you designated two or more beneficiaries and their shares are not specified, they will share any benefit payable equally. If there is no beneficiary change request on file or if none of the beneficiary designations are in effect at time of claim, we will pay as specified in the Certificate.

Please note: You MUST return all pages of this form.

SECTION 1: Plan(s) information

This form can apply to multiple products. This beneficiary designation will apply only to the elections made below.

I elect that the beneficiary designation shown on this form applies only to the following plan(s) insured on my behalf by MetLife.

☐ Group Accident Insurance
Certificate Number:_____

☐ Group Critical Illness Insurance *(includes Group Cancer Insurance)*
Certificate Number: _____

☐ Group Hospital Indemnity *(GCERT16 ONLY)*
Certificate Number: _____

If you wish to have different beneficiaries for different products, you will need to submit separate beneficiary designation forms.

SECTION 2: Insured information

Employer name / Group policyholder name

First name	Middle name	Last name	
Permanent street address	City	State	ZIP
Date of birth	Phone number	Social Security number	

SECTION 3: Beneficiary information

- You **MUST** designate at least one primary beneficiary. **A person may only be listed once.** Anyone listed in the primary section cannot be listed in the contingent section.
- Each Primary and Contingent Beneficiary section **MUST equal 100%.**
- Dollar amounts, fractions and decimals will not be accepted.

Please complete the section that pertains to the type of beneficiary the insured is designating.

☐ **A. Individual Beneficiary**

Primary Beneficiary
Your first choice to receive the insurance proceeds for the plan(s) identified above in the event of your death. If any primary beneficiary(ies) predecease you, that person's share will be equally divided among any remaining primary beneficiary(ies). If more space is needed to list your beneficiaries, please attach a separate sheet to this form.

First name	Middle name	Last name		**Share %**
Permanent street address		City	State ZIP	
Relationship to employee	Date of birth	Social Security number	Phone number	

First name	Middle name	Last name		**Share %**
Permanent street address		City	State ZIP	
Relationship to employee	Date of birth	Social Security number	Phone number	

Contingent Beneficiary
Your second choice to receive the insurance proceeds for the plan(s) identified above if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First name	Middle name	Last name		**Share %**
Permanent street address		City	State ZIP	
Relationship to employee	Date of birth	Social Security number	Phone number	

First name	Middle name	Last name		**Share %**
Permanent street address		City	State ZIP	
Relationship to employee	Date of birth	Social Security number	Phone number	

☐ **B. Living Trust -** ☐ Primary ☐ Contingent

If this form is executed by you, it is understood and agreed that if MetLife receives satisfactory proof that the living trust has been revoked or is not in effect at your death, the beneficiary shall be your Estate, unless otherwise indicated on this form.

Trustee - First name	Middle name	Last name	Share %
Trustee - Permanent street address	City	State / ZIP	
Trust name		Phone number	

☐ **C. Testamentary Trust Created in the Insured's Will -** ☐ Primary ☐ Contingent — **Share %**

The trustee under my last Will and Testament shall be admitted to probate. A copy of the will is required before the claim can be settled.

☐ **D. Insured's Estate -** ☐ Primary ☐ Contingent — **Share %**

If your Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

☐ **E. Charity/Organization -** ☐ Primary ☐ Contingent

Be sure to name the charity or organization and not the charity or organization director or an employee of that charity/organization.

Charity/Organization name		Phone number	% of Proceeds
Permanent street address	City	State / ZIP	

SECTION 4: Signature

☐ Check if you are completing and signing this form as agent for the employee under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section 3 as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured *(Please print)*

First name	Middle name	Last name

Sign Here Signature _____ Date *(mm/dd/yyyy)* _____

SECTION 5: How to submit this form

Return this signed and completed form to the address below. Retain a copy for your records.

Regular mail:
MetLife
PO Box 80826
Lincoln, NE 68501-0826

Toll free telephone number:
1-(866) 626-3705

Fax number:
1-(855) 306-7350

Please note: You MUST return all pages of this form.