Group Life Claims Division

LIFE INSURANCE CLAIM FORM

MetLife®
Metropolitan Life Insurance Company

Employer's Statement

Social Security Number	Name of Insured Employee: Last / First / Middle	Date of Death: Mo. Day Yr.	Date of Birth: Mo. Day Yr.	Sex: M F

Name of Employer _____

Division or Subsidiary and Location _____

Dependent Claim Only

Date of Birth: Mo. Day Yr.	Sex: M F	Amount of Dependent Life Insurance	Name of Deceased Dependent: Last / First / Middle

Notice: Be sure to consider any reduction formula applicable to each type of Life Benefit inforce when entering the amount of Life Benefits for which claim is made.

Report Number	Sub Code	Branch	Type of Life Benefits Check applicable box(es)	Amount
			☐ Basic Life	
			☐ Optional Life*	
			☐ Dependent Life	
			☐ Group Life Plus	
			☐ AD&D	
			☐ VAD&D	
			☐ Group Universal Life**	
			☐ Spouse Group Universal Life	
			☐ Group Variable Universal Life	
			☐ Spouse Group Variable Universal Life	

Complete the Following:

Employee is: ☐ Hourly ☐ Salaried or ☐ Union ☐ Non-Union or ☐ Exempt ☐ Non-Exempt

Base Annual Earnings $ _____ As of Date: Mo. Day Yr.

Did the employee increase coverage more than one benefit level at any time? ☐ Yes ☐ No Indicate Date Mo. Day Yr.

Check if Settlement Option instruction is attached ☐

*Optional Life includes Supplemental Life, Additional Life and Voluntary Life Benefits.
**For more information concerning Group Universal Life coverage, please call 1-800-523-2894.

Please complete information below:

☐ Active Employee: Enter the effective date of amount of insurance being claimed Mo. Day Yr.

☐ Retired Employee: Date retired Mo. Day Yr.

For employees who were not actively at work, please indicate status of employee at date of death (select one item): ☐ Regular Retiree ☐ Retiree Due to Disability ☐ Terminated Due to Disability ☐ Terminated For Any Other Reason ☐ Leave of Absence/Layoff/Sick Leave ☐ Disabled (not terminated or retired)

On what date did the employee last work? Mo. Day Yr. Reason for stopping _____

Was the employer-employee relationship terminated before death? ☐ No ☐ Yes Date Mo. Day Yr. Reason _____

Was life insurance cancelled? ☐ No ☐ Yes Date Mo. Day Yr.

Was a Total and Permanent Disability claim ever filed with MetLife for this employee? ☐ No ☐ Yes Approval Number: _____

Survivor Income Benefit: If the deceased employee qualified for Survivor Income Benefits, and such benefits are covered by MetLife, specify if the claim ☐ is attached, or ☐ will follow.
If check is to be sent to anyone other than claimant, please provide the following information:
Send Life Insurance Benefits to:

_____

_____

_____

(Signature of Employer's Authorized Representative) (Date) (Telephone No.)

Claimant's Statement

Please Complete this form and return it to the Employer of the Deceased Employee with the original or certified copy (evidenced by the discernible raised seal) of the Death Certificate.

1. Residence of Deceased _____
(Number and Street) (City or Town) (State) (Zip Code)

2. Marital Status of Deceased ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

3. Date of Birth of Deceased Mo. Day Yr.

4. Your Name (Print) _____ Your Soc. Sec. No. _____ Date of Birth Mo. Day Yr.

State your relationship to the Deceased ☐ Spouse ☐ Child ☐ Other _____ Your Sex ☐ M ☐ F
(Explain)

Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number, and that: (please check one)

☐ **the Internal Revenue Service (IRS) has notified me that I am subject to backup withholding as a result of a failure to report all interest or dividends, or**

☐ **I am not subject (or no longer subject) to backup withholding.**
The IRS does not require your consent to any provision of this document other than the certifications to avoid backup withholding.

The information I have given is, to the best of my knowledge, true and accurate.

If the Insured was covered under a policy issued in one of the states listed below, **or** if you reside in one of the states listed below, one of the following state warnings may apply to you:

New York: [only applies to Accident and Health Benefits (AD&D/VAD&D)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

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

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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

If the insured was covered under a policy issued in any state other than those listed above, **or** if you reside in any state other than those listed above, then the following warning may apply to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application or a 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.

Date _____ Your Signature _____
(Use your given first name—Do not use, i.e., Mrs. John Doe) (If signature is by mark, witness must sign following mark)

Your Mailing Address (Print) _____
(Number and Street) (City or Town) (State) (Zip Code)

Your Phone Number Day (_____) _____ Evening (_____) _____
(Area Code) (Area Code)

5. If you reside outside the United States, are you a U.S. Citizen? ☐ No ☐ Yes

Claimant—Important Notice

You may elect to receive payment of the Life Benefits in one lump sum or leave all or part of the money with Metropolitan Life Insurance Company ("MetLife") to be paid to you in installments. The booklet, "Important Message To Group Life Benefits Beneficiaries," Form G10070-BENE, describes several installment arrangements whereby a part or all of the Life insurance benefit may be left with MetLife at favorable interest rates under an arrangement you feel will best suit your needs. Your choice of an arrangement will be limited if the insured had previously elected a settlement arrangement.

Your choices are:
☐ I have elected one of the installment arrangements by completing the applicable portions of the booklet, Form G10070-BENE.
☐ I wish settlement to be made in one lump sum.