# MetLife

## Group Term Life Insurance Beneficiary Designation

<ul> <li>This form MUST be signed before you return it. See "SECTION III – Signature" on page 3.</li> </ul>									
Utility Field 1	Utility Field 2	2 Utility Field 3 Utility Field 4		ield 4					
SECTION I - Insu	red Information				_				
Customer Number				Policyholde	r Name/Group Policyholder Name				
First Name		Middle Name		Last Name					
Address – Street		City		State	ZIP Code				
Date of Birth		Phone Number ()		SSN					

## **SECTION II - 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.
- The sum of the Primary Beneficiary percentages **MUST equal 100%**. The sum of the Contingent Beneficiary percentages **MUST equal 100%**. Dollar amounts, fractions and decimals will not be accepted.
- If you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

#### Please complete the section that pertains to the type of beneficiary you are designating.

#### A. Individual Beneficiaries

**PRIMARY BENEFICIARY -** Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name		Middle Initial	Last Name			Share: %
Address – Street		City		State	ZIP Code	
Relationship to Participant	Social Securi	ty Number	Date of Birth	Phone Nu (  )	imber	
First Name		Middle Initial	Last Name			Share: %
Address – Street		City		State	ZIP Code	
Relationship to Participant	Social Securi	ty Number	Date of Birth	Date of Birth Phone Number		
First Name		Middle Initial	Last Name			Share: %
Address – Street		City		State	ZIP Code	
Relationship to Participant	Social Securit	ty Number	Date of Birth	Phone Nu (  )	imber	

**CONTINGENT BENEFICIARY** - Your second choice to receive your life insurance proceeds 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 Initial	Last Name	Last Name		
Address – Street		City		State	ZIP Code	
Relationship to Participant Social Securit		ty Number	Date of Birth	Phone N	Phone Number ( )	
First Name						
First Name		Middle Initial	Last Name			Share: %
First Name Address – Street		Middle Initial	Last Name	State	ZIP Code	

#### B. Living Trust – Primary Contingent

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by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name		Trust Date Trustee Phone Number			Share: %
Trustee - First Name	Middle Initial	Last Name			
Trustee Address – Street	City		State	ZIP Code	

	C. Testamentary	y Trust Creat	ed in the Insure	ed's Will	-	Primary	Contingent	
Γhe	trust(ee) under anv	last Will and Te	stament of mine a	s shall be ac	dmit	ted to probate	<u>e</u>	

Share: %

**D**.

D. Insured's Estate – 
Primary 
Contingent

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

### **E.** <u>Charity/Organization</u> – Primary Contingent

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

Charity/Organization Name		Phone Number ( )		Share: %
Address – Street	City	State	ZIP Code	

#### **SECTION III - Signature**

Check if you are completing and signing this form as agent for the participant 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 II as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

## Insured/Owner Name (Please Print)

**Insured/Owner Signature** 

Date (must be date form was completed)

#### How to Submit This Form

The participant should provide the completed form to their policyholder or benefits administrator. Retain a copy for your records.

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