



Group Life Claims
P.O. Box 3016
Utica, NY 13504

Employer Instructions for Filing Group Life Insurance Claims

1. Detach this page and complete the Employer's Statement on the following page.
2. Give the beneficiary the remaining pages of this claim folder so that he or she may complete the Claimant's Statement

The beneficiary must complete his or her own Claimant's Statement and return it to you, along with a certified copy of the death certificate.

Note: If there is more than one beneficiary, a separate Claimant's Statement must be completed by *each* beneficiary. However, only *one* Employer's Statement and *one* death certificate is needed for processing the claim.

3. Submit the following to the Mass Group Marketing for processing:

Mass Group Marketing
2121 N. Glenville Road
Richardson, TX
75082

- a) the completed Employer's Statement
- b) the Claimant's Statement(s)*
- c) a certified copy of the death certificate
- d) all other pertinent claim information (such as enrollment forms and beneficiary designations)

A certified copy of a death certificate is one that has been certified by the local Bureau of Vital Statistics or other responsible agency, and bears a raised or colored seal. Claimants can usually obtain this document from the funeral director who handled the arrangements.

If any of the above information is omitted, please give us full details as to what is omitted and why.

4. Contact the MetLife Administrator responsible for your group if you have further questions.

*If there are multiple beneficiaries, please submit each completed Claimant's Statement as you receive it. By doing so, you will help us speed payment to those beneficiaries who have returned their completed Statements. If a beneficiary is deceased, please submit a copy of the Death Certificate with the claim.



Life Insurance Claim Form Employer's Statement

For MetLife Use Only

To avoid processing delays, please provide all information requested. This form must be completed by an authorized company representative. Please print or type.

Claim is for: Employee or Dependent

Section A: Employee/Member Information				
Employee Social Security Number	Name of Insured Employee			Sex
____/____/____	Last	First	Middle	M or F
Date of Death: ____/____/____ Date of Birth: ____/____/____ Employee's Occupation: _____				
Date of Hire: ____/____/____				
Was Insurance ever assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach a copy of assignment and all related papers)				
<input type="checkbox"/> Active Employee: Enter the effective date of amount of insurance being claimed ____/____/____				
<input type="checkbox"/> Retired Employee: Date retired ____/____/____				
For employees who were not actively at work, please indicate status of employee at date of death (select one):				
<input type="checkbox"/> Regular Retiree <input type="checkbox"/> Retiree Due to Disability <input type="checkbox"/> Terminated Due to Disability <input type="checkbox"/> Terminated For Any Other Reason				
<input type="checkbox"/> Leave of Absence/Layoff/Sick Leave <input type="checkbox"/> Disabled (not terminated or retired)				
On what date did the employee last work? ____/____/____ Reason for stopping _____				
Date premium payments for employee stopped ____/____/____				
Was the employer-employee relationship terminated before death? <input type="checkbox"/> No <input type="checkbox"/> Yes Date ____/____/____ Reason _____				
Was life insurance cancelled? <input type="checkbox"/> No <input type="checkbox"/> Yes Date ____/____/____				
Was a Total and Permanent Disability or Continued Protection (CP) disability waiver claim ever filed with MetLife for this employee?				
<input type="checkbox"/> No <input type="checkbox"/> Yes Disability Case Number _____				

Mass Group Marketing
2121 N. Glenville Road
Richardson, TX
75082

(Continued on following page)

**Life Insurance Claim Form
Employer's Statement (cont'd)**

Section B: Employer/Association Information

Name of Employer/Association				Contact Name	
Employer Address Number and Street City State Zip				Employer Telephone Number Fax Number	
Division name and address where employee/member worked (If different than above) Name Number and Street City State Zip					

Notice: Be sure to consider any reduction formula applicable to each type of Life Benefit in force when entering the amount of Life Benefits for which claim is made.						Complete the Following: Employee is: <input type="checkbox"/> Hourly or <input type="checkbox"/> Salaried or <input type="checkbox"/> Union or <input type="checkbox"/> Non-Union <input type="checkbox"/> Exempt or <input type="checkbox"/> Non-Exempt Base Annual Earnings \$ _____ As of Date: ____/____/_____ Did the employee increase coverage within the last two years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate Date: ____/____/_____ 					
Report Number	Sub Code	Branch	Type of Life Benefits Check applicable box(es)	Amount	Effective Date						
			<input type="checkbox"/> Basic Life								
			<input type="checkbox"/> Optional Life*								
			<input type="checkbox"/> Dependent Life								
			<input type="checkbox"/> AD&D***								
			<input type="checkbox"/> Optional AD&D***								
			<input type="checkbox"/> Dependent AD&D***								

***If Accidental Death benefits are claimed, please include supporting documentation such as newspaper clippings, police reports, toxicology reports, autopsy reports, etc.

Survivor Income Benefit: If the deceased employee qualified for Survivor Income Benefits insured by MetLife, specify if the claim is attached, or will follow.

Section C: Deceased Dependent Information

Dependent Claim Only	Date of Death	Date of Birth	Sex M or F	Dependent's Social Security Number	Name of Deceased Dependent Last	First	Middle	Relationship
								Spouse <input type="checkbox"/> Child <input type="checkbox"/>

Signature of Employer's Authorized Representative _____ Date _____ Telephone No. _____

Send benefit payment to: Directly to Beneficiary (ies)

Other: _____



Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 3016
Utica, NY 13504
1-800-638-6420

Dear Claimant:

We at MetLife are sorry for your loss. To help you through what can be a very difficult, emotional, and confusing time, we created a settlement option, the Total Control Account[®] Money Market Option, to give you the time you need to best decide how to use your insurance or annuity proceeds.

If the amount of proceeds payable to you is \$5,000 or more, a Total Control Account will usually be established in your name once your claim is approved. You will receive a personalized "checkbook" and a kit that includes a Customer Agreement and gives you additional information regarding your Account. By using one of your personalized "checks," you can draw a draft on your Total Control Account for the entire amount at any time. Information regarding the other settlement options available will also be provided.

While your money is in a Total Control Account, it is guaranteed by MetLife. You can access all or part of the insurance proceeds at any time, simply by writing one of your checks. You are not charged for checks, there are no transaction or monthly fees, and there are no penalties for withdrawing all or part of your money.

We hope that the Total Control Account will help you rest a little easier knowing that your money is guaranteed, earning a competitive interest rate, and accessible to you when you need it, giving you time to make financial decisions that are right for you. Please read the additional information regarding the Total Control Account provided in this folder.

If you have further questions about this claim, please call our toll-free Customer Service Center 1-800-638-6420.

Once again, we extend our condolences and assure you that we will make every effort to help you in every way we can.

The TOTAL CONTROL ACCOUNT® Money Market Option
Designed to Put YOU in Complete Control of Your Life Insurance Proceeds

The Total Control Account provides...

SECURITY

- The entire amount of your Account, including all interest earned, is fully guaranteed by MetLife.

COMPETITIVE RATES

- The Account earns interest at money market rates that are responsive to current market conditions.
- Interest is compounded daily and credited monthly. (Generally, the interest earned will be subject to income tax.)

FREE CHECKING

- You can write checks from a minimum amount of \$250 up to the full amount in the Account at any time.
- There are no monthly service or transaction charges. There is no charge for printing or reordering checks.

CONVENIENCE

- A personalized checkbook provides you with easy and immediate access to the funds.
- You will receive a monthly statement, showing all transactions, interest earned and the balance in the Account.

FLEXIBILITY

- You can withdraw all or part of your money at any time, without penalty or loss of interest.
- There are no limits on the number of checks you can write each month.
- You can name a beneficiary to receive money held in the Account, in case something happens to you.

FULL SERVICE

Dedicated Service Representatives are within easy reach to answer any questions you may have about your account. You will be provided with a toll-free customer service number with your starter kit materials

TIME TO DECIDE

- Your rights to elect all other available MetLife settlement options are preserved. You may, at any time, place some or all of the money in your Account in any other available option.
- MetLife has a range of settlement options for you to choose from, including Total Control Account Guaranteed Interest Certificates. You will receive complete information on all settlement options which are available to you along with the Total Control Account Money Market Options materials.

The Total Control Account Money Market Option gives you:

Security • Convenience • Flexibility • Free Checking • Competitive Interest

If the proceeds payable to you are less than \$5,000, or you reside in a foreign country, or the claimant is a corporation or similar entity—and the insured did not designate a settlement option, payment is usually made by a single, lump-sum check. If the insured designated an alternative settlement option, that designation will be carried out. In this case, more information will be provided to you as your claim is processed.

Guarantees are subject to the financial strength and claims-paying ability of Metropolitan Life Insurance Company. Total Control Accounts® is a registered service mark of Metropolitan Life Insurance Company

Life Insurance Claim Form
Claimant's Statement

For MetLife Use Only

Employer Name: _____

Employee Name: _____

In order to process your claim as quickly as possible we need some information about you and about the deceased. Each beneficiary must submit his or her own Claimant's Statement. Return this completed Claimant's Statement to the Employer or directly to MetLife, in accordance with the instructions you received with this form. Be sure to include a certified copy of the death certificate that indicates the cause and manner of death. A certified copy of the death certificate is one that has been certified by the local Bureau of Vital Statistics or other responsible agency, and bears a raised or colored seal. You can usually obtain one from the funeral director who handled the arrangements.

Additional Information if Beneficiary is a Minor:

If no legal guardian is appointed to handle the minor's estate, a responsible adult should complete and sign the Claimant's Statement on behalf of the minor beneficiary. Be sure to complete Section A with information regarding the minor, not the party completing the form.

If a legal guardian of the minor child's estate has been or will be appointed, the guardian must complete and sign the Claimant's Statement. Be sure to include a copy of court-issued guardianship papers in the claim submission to MetLife.

A. Information about you:

1. Your Name (please print or type) _____
First Middle Initial Last

Maiden Name (if applicable) _____

2. Social Security No. . _____ / _____ / _____

3. Date of Birth _____ Male Female
Mo. Day Year

4. Phone Number Day (_____) _____ Evening (_____) _____
(Area Code) (Area Code)

5. Fax Number (optional) (_____) _____
(Area Code)

6. Mailing Address _____
Number Street Apt./Box No. (if any)

City State Zip

7. Relationship to the deceased
 You are the Spouse Child Parent Other _____
Explain

8. If you have signed a document with a funeral home (a funeral home assignment) that authorizes MetLife to make a payment directly to it, please check here

B. Information about the deceased:

1. His/Her Name _____
First Middle Initial Last

Maiden Name (if applicable) _____

2. Residence Address _____
Number Street Apt./Box No. (if any)

City State Zip

3. Marital Status Single Married Widow/Widower Separated Divorced

4. Date of Birth _____
Mo. Day Year

5. Social Security No. _____ / _____ / _____

6. If the deceased person also had an individual life insurance policy with MetLife, please provide the policy number:

Life Insurance Claimant's Statement (cont'd)

Employee Name: _____

C. Certifications and Signature:

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

Under penalty of perjury, I certify:

- 1) That the number shown on this form is my correct taxpayer identification number; and
- 2) That I am not subject to backup withholding because: (a) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (b) that I am no longer subject to backup withholding; and
- 3) I am a U.S. citizen, or a U.S. resident for tax purposes.

Please note: Cross out and initial item 2 and/or item 3 if subject to backup withholding as a result of a failure to report all interest and dividend income or you are not a U.S. citizen or U.S. resident for tax purposes.

Our standard payment method is in the form of a **Total Control Account**. A personalized checkbook and a kit that includes information about your Account will be sent to you if an Account is established. Your Account will be guaranteed by MetLife and your money will be accessible to you when you need it.

Please sign below as you would sign on checks (include first and last name). If you are receiving a Total Control Account, this signature will be placed on file with your Account. If Beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor.

The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

_____ Beneficiary Signature	_____ Date
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FRAUD WARNINGS

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:

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

Alaska, Delaware, Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, New Mexico: 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 civil fines and criminal penalties.

California: Any person who knowingly presents a false or fraudulent 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 life insurance, and civil damages. It is also unlawful for 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 respect to a settlement or award payable from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies to the extent required by applicable law.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

Kentucky: Any person who knowingly and with the intent to defraud any insurance company or other person files 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.

Indiana, Minnesota, Oklahoma: WARNING: Any person who knowingly, and with the 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.

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

Ohio: A person who, with 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 is guilty of insurance fraud.

Pennsylvania: 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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 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 may be a crime and may subject such person to criminal and civil penalties.