Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
1-800-638-6420

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 MetLife Group Life Claims Office for processing:
   MetLife
   Group Life Claims
   Scranton, PA 18505-6100
   (Fax) 1-570-558-8645
   1-800-638-6420

   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 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.

As an alternative, you may submit the completed Employer's Statement, enrollment forms, and beneficiary designations directly to MetLife, and provide each beneficiary with the Claimant's Statement. Each beneficiary can then complete and sign the Claimant's Statement and submit it to MetLife with a certified copy of the death certificate. Only one death certificate need be submitted.

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 Last / First / Middle	Sex M or F
| | | | | | | |		

Date of Death: _____/_____/________ Date of Birth: ___/_____/________ Employee's Occupation: ____________________

Date of Hire: ___/___/________

Was Insurance ever assigned? ☐ Yes ☐ No (If yes, please attach a copy of assignment and all related papers)

☐ Active Employee: Enter the effective date of amount of insurance being claimed _____/_____/________

☐ Retired Employee: Date retired _____/_____/_________

For employees who were not actively at work, please indicate status of employee at date of death (select one):

☐ 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? ___/_____/________ Reason for stopping____________________

Date premium payments for employee stopped ___/_____/__________

Was the employer-employee relationship terminated before death? ☐ No ☐ Yes Date _____/_____/_______Reason ____________

Was life insurance cancelled? ☐ No ☐ Yes Date _____/_____/________

Was a Total and Permanent Disability (T&P) or Continued Protection (CP) disability waiver claim ever filed with MetLife for this employee? Leave blank if plan does not include T&P or CP.

☐ No ☐ Yes Disability Case Number____________________

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(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 from above)*
Name | Number and Street | City | State | Zip

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	Effective Date
			☐ Basic Life		
			☐ Supplemental/Optional Life*		
			☐ Dependent Life		
			☐ AD&D***		
			☐ Supplemental/Optional AD&D***		
			☐ Dependent AD&D***		
			☐ VAD&D***		
			☐ Group Universal Life**		
			☐ Spouse Group Universal Life		

Complete the Following:

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

Base Annual Earnings $__________ As of Date: ____/____/__________

Did the employee increase coverage within the last two years?

☐Yes ☐No

If yes, indicate Date: ____/____/________

* **Supplemental/Optional Life includes Additional Life and Voluntary Life Benefits.**

** **For more information concerning Group Universal Life coverage, please call 1-800-523-2894.**

*** **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 ☐ Child ☐

______________________________ Signature of Employer's Authorized Representative

__________ **Date Signed**

__________ **Telephone No.**

Send benefit payment to: ☐ Directly to Beneficiary (ies)

☐ Other:______________________________

MetLife®
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
1-800-638-6420

Life Insurance Claim Form
Claimant's Statement

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. Only one death certificate need be submitted.

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./TIN: ________/________/________
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. ________/________/________

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Life Insurance Claimant's Statement (cont'd)

Employee Name: ______________________________

6. Certified copy of death certificate is ☐ attached (or was previously submitted) ☐ not attached.
   If not attached, please explain ______________________________
7. If the decedent also held an individual life insurance policy with MetLife, please provide the policy number:
   ____

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.

Please sign below (include first and last name). If Beneficiary is a minor, the legal guardian or adult submitting this form must sign it, 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 Signed

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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, Idaho, 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, West Virginia: 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: For your protection, California law requires the following to appear on this form: 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: A 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.

Indiana: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, files any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information commits a felony.

Kentucky: A 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.

Maine, Minnesota, Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

FRAUD WARNINGS, CON'T.

New Hampshire: A person who, with a purpose to injure, defraud or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

New York (AD&D): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.