MetLife

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
1-800-638-6420
Fax: 1-570-558-8645

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 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:

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   P.O. Box 6100
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   (Fax) 1-570-558-8645
   1-800-638-6420

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

   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 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.

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MetLife

Life Insurance Claim Form
Employer's Statement

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

First Name ____________ Middle Name ____________ Last Name ____________

Social Security or Tax ID Number ____________ ☐ Male ☐ Female Date of Birth ____________ Date of Death ____________

Date of Hire ____________ Employee's Occupation ____________

Did the insured assign ownership of the coverage via an absolute, gift or viatical assignment which is on file with the plan records? ☐ 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)

What was the last date the employee was physically doing work? ____________ Reason for stopping ____________ Date premium payments for employee stopped ____________

Was the employer-employee relationship terminated before death? ☐ Yes ☐ No
Date ____________ Reason ____________

Was life insurance cancelled? ☐ Yes ☐ No Date ____________

Is the beneficiary designation available? ☐ Yes ☐ No If Yes, include the most recent designation with claim submission.

Has a Waiver of Premium or Total and Permanent Disability (T&P) claim been filed with MetLife for this insured? ☐ Yes ☐ No
Leave blank if the plan does not have premium waiver or T&P.
Disability Case Number ____________

For MetLife Use Only

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Life Insurance Claim Form - Employer's Statement

Section B: Employer/Association Information

Name of Employer/Association ______ **Employer Telephone Number** ______ **Fax Number** ______

Employer Address - Number and Street ______ City ______ State ______ Zip ______

Contact Name - First ______ Middle ______ Last ______

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*		
			☐ Employer-paid Dependent Life		
			☐ Dependent Life		
			☐ AD&D***		
			☐ Supplemental/Optional AD&D***		
			☐ Dependent AD&D***		
			☐ VAD&D***		
			☐ Group Universal Life**		
			☐ Spouse Group Universal Life		

*** 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.**

Complete the Following: Employee is: ☐ Hourly or ☐ Salaried ▪ ☐ 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 ______

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 ______ Relationship ☐ Spouse ☐ Child

Name of Deceased Dependent - First ______ Middle ______ Last ______

▶ Signature of Employer's Authorized Representative ______ Date Signed ______ Telephone No. ______

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

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Life Insurance Claim Form
Claimant's Statement

Group Life Claims
P.O. Box 6100
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1-800-638-6420

Insured's Employer Name

____

Insured Employee - First Name ______________ Middle Name ______________ Last Name ______________

We at Metropolitan Life Insurance Company (MetLife) are sorry for your loss. 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 copy of the death certificate that indicates the cause and manner of death. You can usually obtain one from the funeral director who handled the arrangements. Only one death certificate need be submitted. Please note that original documents cannot be returned

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 the beneficiary

1. Your Name - First (please print in capital letters or type) ______________ Middle Initial ______ Last ______________

Maiden Name (if applicable) ______________ **2.** Social Security No./TIN ______________ **3.** Date of Birth ______________ ☐ Male ☐ Female

4. Country of Citizenship ______________ **5.** Day Phone Number ______________ Evening Phone Number ______________ **6.** Fax Number (optional) ______________

7. Mailing Address - Number, Street, Apt./Box No. (if any) ______________ City ______________ State ______ Zip ______

8. Relationship to the deceased - You are the ☐ Spouse ☐ Parent ☐ Child ☐ Other - Explain ______________

9. 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 attach the document and 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 ☐ Divorced ☐ Separated ☐ Widow/Widower **4.** Date of Birth ______________ **5.** Social Security No. ______________

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: ______________ or call 1-800-638-5000 for information.

Insured Employee - First Name ______ Middle Name ______ Last Name ______

C. Certifications and Signature

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. That any contributions owed by the insured will be deducted from the insurance proceeds paid to me.
3. MetLife has the right to recover any amounts that it determines to be an overpayment. An overpayment occurs if MetLife determines that: (a) the total amount paid by MetLife on your claim is more than the total amount of benefits due to you under the benefit plan/ insurance certificate; or (b) MetLife made payment to you when the payment should have been made to someone else. In case of an overpayment, I agree to repay MetLife the specifically overpaid funds. I further understand that if an overpayment is not repaid, MetLife reserves the right to rely on any means to recover the overpayment, including institution of litigation.
4. I have read the applicable Fraud Warning(s) provided in this form. **New York Residents:** 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 fact material thereto, commits a fraudulent insurance act, which is 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.

Under penalty of perjury, I certify:

1. **That the number shown as my Social Security Number or Tax Identification Number in "Information about the beneficiary" above is my correct taxpayer identification number, and**
2. **That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) 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 (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen, resident alien, or other U.S. person*, and**
4. **I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.**

(Please note: You must cross out item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

**** If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out items 3 and 4 above, and complete and submit form W-8BEN (individuals) or W-8BEN-E (entities).***

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Please sign below. Include first and last name. If Beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor.

Claimant Signature | Date Signed

______________________ ______________

Life Insurance Claim Form

Claimant's Statement

FRAUD WARNINGS

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and 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 fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

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 a loss is subject to criminal and civil 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 insurance and civil damages. 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 regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with 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.

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

Kentucky: 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 is a crime.

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

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: 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.

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