Metropolitan Life Insurance Company
Telephone Number: 1-800-638-6420

The Accelerated Benefits Option ("ABO")

Please read the following important information before completing the attached ABO claim form:

- Claiming an accelerated benefit will reduce the amount of your life coverage in effect and will reduce any life coverage eligible for conversion.
- If any of your Group Life benefits have been assigned to someone else, the ABO is not available to you or your assignee.

Applying for an Accelerated Benefit

If, after you have given careful consideration to the ABO, you wish to claim an accelerated benefit, please complete the Claimant's Statement and Medical Authorization portion of the claim form, have your doctor provide the requested information including last office visit notes, and return the completed claim form to your Employer.

An Example

The following illustrates in a general way how ABO works. Please refer to your Group Insurance certificate or Summary Plan Description for details of the specific provisions that apply to your coverage.

You currently have $50,000 of Group Life Insurance and your plan allows you to accelerate up to 80% of your coverage if you meet specified criteria.

ABO Provision:	
Your current coverage:	$50,000
Amount accelerated:	$40,000
Remaining Group Life Insurance, subject to continuing plan eligibility:	$10,000

You may elect to accelerate a lower percentage if you wish.

ABO Employer's statement

SECTION 1: Covered employee details

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Social Security number

Name of Employer

Division or Subsidiary and Location

SECTION 2: Dependent spouse claim only

First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Amount of dependent spouse insurance

SECTION 3: Coverage information

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.

Report number	Sub code	Branch	Type of Life Benefits Check applicable box*(es)*.	Amount of Life Insurance payable as of date of claim.	Amount of Life Insurance payable twelve months from date of claim.
			☐ Basic Life		
			☐ Supplemental/Optional Life*		
			☐ Dependent Life		
			☐ Group Universal Life		
			☐ Spouse Group Universal Life		
			☐ Group Variable Universal Life		
			☐ Spouse Group Variable Universal Life		

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

Complete the following:

Employee is:

☐ Hourly ☐ Salaried ☐ Retired ☐ Union ☐ Non-Union ☐ Exempt ☐ Non-Exempt

Base Annual Earnings	As of date *(mm/dd/yyyy)*

SECTION 4: Additional information

☐ Active employee: Enter effective date of amount of insurance being claimed *(mm/dd/yyyy)*

☐ Retired employee: Enter date retired *(mm/dd/yyyy)*

For employees who are not actively at work, please indicate status of employee *(select one item)*:

☐ Regular retiree ☐ Retiree due to disability ☐ Leave of Absence/Layoff/Sick leave

☐ Disabled *(not terminated or retired)*

What was the last date the employee was physically doing work? *(mm/dd/yyyy)*

Reason

Was the employer-employee relationship terminated before accelerated benefits were claimed? ☐ No ☐ Yes

If Yes, what date was the relationship terminated? *(mm/dd/yyyy)*

Reason

Was life insurance cancelled? ☐ No ☐ Yes | If Yes, what date was insurance cancelled? *(mm/dd/yyyy)*

Date premium payments for employee stopped? *(mm/dd/yyyy)*

SECTION 5: Signature

First name | Middle name | Last name

Phone number

Sign Here Signature of Authorized employer representative | Title | Date *(mm/dd/yyyy)*

SECTION 6: How to submit this form

To the employer: Please make certain the Claimant's Statement and the Statement of Attending Physician are properly completed. Please complete the Employer's Statement and submit the claim to:

Mail:
Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

This page intentionally left blank.

Group Life Claims

Metropolitan Life Insurance Company
Telephone Number: 1-800-638-6420

Dear Claimant:

Attached is the material you have requested about MetLife's Accelerated Benefits Option ("ABO") for your Group Insurance plan.

Under the ABO, if you are diagnosed as having a terminal illness, with a life expectancy of twelve months or less, you may be eligible to receive a portion of your Group Life benefits. This option can provide financial assistance and flexibility in a crisis; therefore, it is important that you are aware of it.

The accelerated life insurance benefits offered under your certificate are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the accelerated benefits qualify for such favorable treatment, they will be excludable from your income and not subject to federal taxation. Receipt of accelerated death benefit payments may be taxable for purposes other than federal income tax. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive accelerated benefits excludable from income under federal tax law.

Receipt of accelerated benefits may affect your eligibility, or that of your spouse or family, for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with social services agencies concerning the effect receipt of accelerated benefits will have on public assistance eligibility for you, your spouse, or your family.

Approval of this claim is subject to an independent medical review by MetLife.

Please refer to your Group Insurance certificate or Summary Plan Description for details on the specific ABO provision for your MetLife Group coverage(s).

Sincerely,

MetLife Group Life Products

MetLife

State Specific Fraud Warnings – Group Product Claim Forms

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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: 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.

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

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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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 and 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 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 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.

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

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.

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.

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.

Virginia: Any person who, with the 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 may have violated the state law.

This page intentionally left blank.

MetLife

Accelerated benefits claim form

Claimant's statement

Metropolitan Life Insurance Company

SECTION 1: Covered employee details

First name | Middle name | Last name

Date of birth *(mm/dd/yyyy)* | Social Security number

Residence - Number and street | City or Town | State | ZIP

Telephone number | Marital status of claimant ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Is the claimant the Employee or Dependent spouse? ☐ Employee ☐ Spouse | If spouse, please provide:

Spouse - First name | Middle name | Last name

Spouse's date of birth *(mm/dd/yyyy)* | Spouse's Social Security number

Have any of your Life Insurance benefits been assigned? ☐ Yes ☐ No

If "yes", specify which coverage _____ and $ Amount _____

Select the coverage and amount you wish to accelerate.

- ☐ Basic Life Insurance $_____
- ☐ Supplemental/Optional Life Insurance $_____
- ☐ Dependent Life Insurance $_____
- ☐ Group Universal Life Insurance $_____
- ☐ Spouse Group Universal Life Insurance $_____
- ☐ Group Variable Universal Life Insurance $_____
- ☐ Spouse Group Variable Universal Life Insurance $_____

Payment option desired *(please select one)*: ☐ Lump Sum ☐ Three Monthly Installments

SECTION 2: 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. I have read the applicable Fraud Warning(s) provided in this form.

Medical Authorization *(NOTE: Approval of this claim is subject to an independent medical review by MetLife.)*

I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to this claim.

The covered employee must sign for all claims.

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign Here	Signature of Employee	Date *(mm/dd/yyyy)*
Sign Here	Signature of Spouse *(if claiming accelerated benefits)*	Date *(mm/dd/yyyy)*

Some services in connection with your claim may be performed by our affiliates, MetLife Global Operations Support Center Private Limited or MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your claim will be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

SECTION 3: How to submit this form

Please complete this form and return it to your Employer.

Mail:
Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

Telephone number:
1-800-638-6420

Group Life

MetLife

Statement of Attending Physician

Metropolitan Life Insurance Company

SECTION 1: Patient details

First name	Middle name	Last name

The information provided is to be used for claims evaluation and auditing purpose. Please attach to this form the most recent office visit notes when submitting the patient information.

The patient is responsible for having this form completed without expense to MetLife or the Employer.

If more space is needed, please use reverse side of form.

SECTION 2: History and Diagnosis

A. Date symptoms first appeared or accident occurred *(mm/dd/yyyy)*

B. Date of first visit *(mm/dd/yyyy)*

C. Date of most recent examination *(mm/dd/yyyy)*; please attach most recent office visit notes.

D. Frequency of visits/treatments

E. Past history

F. Objective findings *(including pertinent laboratory test results)*

G. Subjective symptoms

H. State primary diagnosis and use ICD-9 code

State secondary diagnosis and complications, if any, and use ICD-9 code

I. Past, present and future course of treatment

J. Other known injuries or presently active diseases

K. What is patient's functional status, that is, is he or she bedridden, ambulatory, etc.?

SECTION 3: Hospitalization details

Is the patient hospitalized or confined in some other facility? ☐ Yes ☐ No If Yes:

A. Name of hospital/facility	B. Dates of Confinement

C. Address of hospital/facility	City	State	ZIP

First name	Middle name	Last name

SECTION 4: Other requirements

To qualify for this benefit, the patient must suffer from a terminal condition while covered for Life Insurance Benefits. “Terminal condition” means a sickness or an injury which is expected to result in his/her death within 12 months; and from which he/she is not expected to recover.

In your opinion, does the patient meet these requirements? ☐ Yes ☐ No

In your opinion is the patient competent to endorse checks and direct the use of their proceeds? ☐ Yes ☐ No

SECTION 5: Physician details

Physician - First name	Middle name	Last name

Telephone number	Board certified speciality	Provider or ID Number

Address	City	State	ZIP

Sign Here Signature of Physician | Date *(mm/dd/yyyy)*

Statement of Attending Physician