MetLife
Metropolitan Life Insurance Company
Group Life Claims
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.
- Please review your Group Insurance certificate or Summary Plan Description to determine whether a mortality and interest charge is applicable to the ABO provision of your Group Life coverage.
- If applicable under your particular Group Insurance plan, the amount of accelerated benefits you claim will be discounted to collect the interest lost between the time an accelerated benefit is paid out and the average expected time that death occurs. This mortality and interest charge incorporates an assumed rate of return for monies that could have earned interest had the funds not been paid out, and a minimal expense charge. The mortality and interest charge is subtracted from the payout which you have requested to be accelerated, limited by the maximum amount of payout for which you are eligible.
- 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, 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 50% of your coverage if you meet specified criteria.

Non-Discounted ABO Provision:	
Your current coverage:	$50,000
Amount accelerated:	$25,000
Net accelerated payment:	$25,000
Remaining Group Life Insurance Payable to Your Beneficiary:	$25,000

Discounted ABO Provision:	
Your current coverage:	$50,000
Amount accelerated:	$25,000
22% mortality and interest charge (25,000 x .22):	-$5,500
Administrative Fee	-$150
Net accelerated payment:	$19,350
Remaining Group Life Insurance Payable to Your Beneficiary:	$25,000

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

ABO Employer's Statement

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:

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

Name of Covered Employee Last First Middle	Date of Birth (Mo. / Day / Yr.) / /	☐ Male ☐ Female	Social Security Number / /

Name of Employer _____

Division or Subsidiary and Location _____

Dependent Spouse Claim Only

Name of Dependent Spouse Last First Middle	Date of Birth (Mo. / Day / Yr.) / /	☐ Male ☐ Female	Amount of Dependent Spouse Insurance

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 24 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:
___/___/_____

Please Complete Information Below:

☐ Active Employee: Enter effective date of amount of insurance being claimed	(Mo. / Day / Yr.) / /

☐ Retired Employee: Enter date retired	(Mo. / Day / Yr.) / /

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)

On what date did the employee last work?

(Mo. / Day / Yr.)
/ /

Reason _____

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

If Yes, what date was the relationship terminated? (Mo. / Day / Yr.) / /

Reason _____

Was life insurance cancelled? ☐ No ☐ Yes If Yes, what date was insurance cancelled?	(Mo. / Day / Yr.) / /

Employer's Authorized Representative:

Name _____ Title _____ Phone # _____

Signature _____ Date Signed _____

MetLife
Metropolitan Life Insurance Company
Group Life Claims
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 24 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

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.

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.

Arkansas, District of Columbia, Louisiana, Minnesota, New Mexico, Ohio, Oregon 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.

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 and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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.

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: Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

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

ACCELERATED BENEFITS CLAIM FORM
Claimant's Statement

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

Please complete this form and return it to your Employer.

1. Name of Covered Employee Last First Middle	Employee's Date of Birth (Mo. / Day / Yr.) / /	☐ Male ☐ Female	Employee's Social Security Number / /

2. Residence _____ _____ _____ _____
Number and Street City or Town State Zip Code

Telephone Number (____) _____

3. Marital Status of Claimant ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

4. Is the claimant the Employee or Dependent Spouse? ☐ Employee ☐ Spouse

If spouse, please provide:

Name of Spouse Last First Middle	Spouse's Date of Birth (Mo. / Day / Yr.) / /	☐ Male ☐ Female	Spouse's Social Security Number / /

5. Have any of your Life Insurance benefits been assigned? ☐ Yes ☐ No
If "yes", specify which coverage _____ (coverage) and amount $ _____ (amount)

6. Select the coverage and amount you wish to accelerate. The minimum claim amount is $5,000.

☐ 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 $ _____

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

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.

_____ _____
Employee Signature Date Signed

_____ _____
Spouse's Signature (if claiming accelerated benefits) Date Signed

Statement of Attending Physician

Patient's Name _____

The information provided is to be used for claims evaluation and auditing purposes only.

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.

History and Diagnosis

Does the condition, in whole or part, result from an intentionally self-inflicted injury or suicide attempt?

A. Does the condition, in whole or part, result from an intentionally self-inflicted injury or suicide attempt?
☐ Yes ☐ No
If yes, please explain _____

B. Date symptoms first appeared or accident occurred _____

C. Date of first visit _____

D. Date of most recent examination _____

E. Frequency of visits/treatments _____

F. Past history: _____

G. Objective findings (including pertinent laboratory test results): _____

H. Subjective symptoms: _____

I. State primary diagnosis and use ICD-9 code: _____

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

J. Past, present and future course of treatment: _____

K. Other known injuries or presently active diseases: _____

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

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

A. Name of hospital/facility _____

B. Address of hospital/facility _____

C. Dates of Confinement _____

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 24 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

Name of Physician	Board Certified Specialty

Street Address	City or Town	State	Zip Code

( ) Telephone Number	Date Signed	Signature

Statement of Attending Physician (Continued)

Patient's Name _____