MetLife®
Metropolitan Life Insurance Company, New York, NY

ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is either the Employer, TPA or MetLife.)

1. Immediately upon the Insured's termination of employment, complete Part A below and make two copies of this form
2. Provide the Eligible Insured with the original or mail it to their last known address.
3. **Mail a copy of this form to MetLife Recordkeeping Center, P.O. Box 6169, Utica, NY 13504-6169.**
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER

Employer Name:	Group Report No.:	Sub Division:	Branch:	Portable No.:
Insured Coverage Termination Date:	**Date of This Notice:**			
Insured Name: (Last, First, Initial)	Social Security Number:		Date of Birth:	Sex: (M/F)
Insured Mailing Address: (Street, City, State, Zip)			Insured Home Telephone No.:	
Annual Salary at Coverage Termination: $	Reason for Termination:			

Has Coverage Been Assigned? ☐ Yes ☐ No

If yes, please specify coverage assigned _____ and attach a copy of assignment form.

Was the insured actively at work on the date of separation? ☐ Yes ☐ No

Recordkeeper Name: _____

Name of Person Completing Part A: _____ Telephone Number: _____

Employer To Verify Insurance Amount(s) In Effect At Termination Date:

METLIFE INSURED COVERAGE AMOUNTS IN EFFECT:

	Life Insurance Amount
Insured: Supplemental/Optional Life	$_____

If you are a resident of Vermont, Portable Term coverage is not available to you. If you are a resident of the state of Michigan, there is a limit to the amount of coverage you are allowed to port. This limit applies to your combined Term Life coverages for a covered person, it does not apply to AD&D coverages. For specific details about this limit, contact the MetLife Recordkeeping Center 1-866-492-6983.

MetLife provides coverage under a Group Insurance policy (Policy Number 93211-G) issued to the Chase Manhattan Bank, N.A., as Trustee. All Portable Term coverage terminates when your premium payments cease, or January 1 of the year in which you attain age 80. Portable Term insurance does not provide payment for death caused by suicide within the first two years (one year in Colorado or North Dakota) from the effective date of your coverage under your employer's Group Life Insurance benefit plan (except in Massachusetts, Missouri and Washington).

Part B – TO BE COMPLETED BY THE INSURED

Insured Application Period: The Insured must apply for portable coverage within 31 days from the date benefits were terminated or 45 days from the date this notice is given, if notice is given more than 15 days but less than 90 days after the date benefits were terminated.	You may continue coverage at the same amount you had at the time of coverage termination or at a lesser amount. The employee minimum is $20,000; the maximum is equal to the life insurance amount at time of coverage termination or $1,000,000, whichever is less. At age 70, your coverage will be reduced by 50%.

Portable Insurance Amount(s) Requested (Please Round Coverage to the nearest thousand)

	Same Amount	Decreased Amount[1]	No Coverage
Insured:[2] Supplemental/Optional Life	☐	$_____	☐

NOTE: All coverage amounts are subject to applicable state laws.

1. Specify the amount of coverage you prefer. The coverage amount selected may not exceed the coverage amount under the former plan.
2. In order to elect Portable coverage, you must have had the selected coverage under the former plan.

(Continued on Following Page)

ELECTION OF PORTABLE COVERAGE FORM (Continued)
TO BE COMPLETED BY THE INSURED (Continued)

DESIGNATION OF BENEFICIARY FOR INSURED LIFE BENEFITS

☐ I Designate as my Primary Beneficiary: ☐ My Designation of Beneficiary is on a separate form which is signed, dated and attached.

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
			TOTAL:	100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
			TOTAL:	100%

Unless designated otherwise, payment will be made in equal shares or all to the survivor.
I RESERVE the right to change this designation at any time.

Insured Signature: _____ Date of Signature _____ (Mo./Day/Yr.)

Fraud Warning:

If you are applying for insurance under a policy issued in one of the following states, or if you reside in one of the following states, note the following applicable warning:

New York **[only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.**

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

Massachusetts**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.**

New Jersey**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

Oklahoma**: 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, Oregon, and Vermont**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject 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.**

Virginia 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 include imprisonment, fines and denial of insurance benefits.**

If you are applying for insurance under a policy issued in any state other than those listed above, or if you reside in any state other than those states listed above, note the following warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Insured/Assignee Signature:	Date: