

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, and return the completed claim form to your Plan Administrator.

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 Payable to Your Beneficiary:	\$10,000

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

ABO Plan Administrator's Statement

To the plan administrator: Please make certain the Claimant's Statement and the Statement of Attending Physician are properly completed. Please complete the Plan Administrator'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 Participant Last	First	Middle	Date of Birth (Mo. / Day / Yr.) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number / /
Name of Plan Administrator _____					
Division or Subsidiary and Location _____					

Dependent Spouse Claim Only					
Name of Dependent Spouse Last	First	Middle	Date of Birth (Mo. / Day / Yr.) / /	<input type="checkbox"/> Male <input type="checkbox"/> 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 twelve months from date of claim.	
			<input type="checkbox"/> Basic Life			
			<input type="checkbox"/> Supplemental/Optional Life*			
			<input type="checkbox"/> Dependent Life			
			<input type="checkbox"/> Group Universal Life			
			<input type="checkbox"/> Spouse Group Universal Life			
			<input type="checkbox"/> Group Variable Universal Life			
			<input type="checkbox"/> Spouse Group Variable Universal Life			
* Supplemental/Optional Life includes Additional Life and Voluntary Life Benefits.						

Please Complete Information Below:

<input type="checkbox"/> Active Participant: Enter effective date of amount of insurance being claimed	(Mo. / Day / Yr.) / /	<input type="checkbox"/> Retired Participant: Enter date retired	(Mo. / Day / Yr.) / /
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For participants who are not actively at work, please indicate status of participant (select one item):

Regular Retiree Retiree Due to Disability Leave of Absence/Layoff/Sick Leave Disabled (not terminated or retired)

Was the plan administrator-participant 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? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, what date was insurance cancelled?	(Mo. / Day / Yr.) / /	Date premium payments for participant stopped?	(Mo. / Day / Yr.) / /
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Plan Administrator's Authorized Representative:

Name _____ Title _____ Phone # _____

Signature _____ Date Signed _____

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

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 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 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.

ACCELERATED BENEFITS CLAIM FORM
Claimant's Statement

MetLife
 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 Plan Administrator.

1. Name of Covered Participant Last _____ First _____ Middle _____	Participant's Date of Birth (Mo. / Day / Yr.) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Participant's Social Security Number / /
2. Residence _____ Number and Street _____ City or Town _____ State _____ Zip Code _____ Telephone Number (_____) _____			
3. Marital Status of Claimant <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
4. Is the claimant the Participant or Dependent Spouse? If <input type="checkbox"/> Participant <input type="checkbox"/> Spouse spouse, please provide:			
Name of Spouse Last _____ First _____ Middle _____	Spouse's Date of Birth (Mo. / Day / Yr.) / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse's Social Security Number / /
5. Have any of your Life Insurance benefits been assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", specify which coverage _____ and amount \$ _____ (coverage) (amount)			
6. Select the coverage and amount you wish to accelerate.			
<input type="checkbox"/> Basic Life Insurance \$ _____	<input type="checkbox"/> Group Universal Life Insurance \$ _____	<input type="checkbox"/> Spouse Group Universal Life Insurance \$ _____	
<input type="checkbox"/> Supplemental/Optional Life Insurance \$ _____	<input type="checkbox"/> Group Variable Universal Life Insurance \$ _____	<input type="checkbox"/> Spouse Group Variable Universal Life Insurance \$ _____	
<input type="checkbox"/> Dependent Life Insurance \$ _____			
7. Payment option desired (please select one): <input type="checkbox"/> Lump Sum <input type="checkbox"/> 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, plan administrator, hospital, physician or pharmacist to release any information requested with regard to this claim.

The covered participant must sign for all claims.

Participant Signature _____	Date Signed _____
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Spouse's Signature (if claiming accelerated benefits) _____	Date Signed _____
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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 Plan Administrator.
If more space is needed, please use reverse side of form.

<p>History and Diagnosis Does the condition, in whole or part, result from an intentionally self-inflicted injury or suicide attempt?</p> <p>A. Does the condition, in whole or part, result from an intentionally self-inflicted injury or suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____ _____</p> <p>B. Date symptoms first appeared or accident occurred _____</p> <p>C. Date of first visit _____</p> <p>D. Date of most recent examination _____</p> <p>E. Frequency of visits/treatments _____</p> <p>F. Past history: _____ _____</p> <p>G. Objective findings (including pertinent laboratory test results): _____ _____ _____</p>	<p>H. Subjective symptoms: _____ _____ _____</p> <p>I. State primary diagnosis and use ICD-9 code: _____ _____ _____ State secondary diagnosis and complications, if any, and use ICD-9 code: _____ _____ _____</p> <p>J. Past, present and future course of treatment: _____ _____ _____</p> <p>K. Other known injuries or presently active diseases: _____ _____</p> <p>L. What is patient's functional status, that is, is he or she bedridden, ambulatory, etc.? _____ _____ _____</p>
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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 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

_____ Name of Physician	_____ Board Certified Specialty
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_____ Street Address	_____ City or Town	_____ State	_____ Zip Code
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(____) _____ Telephone Number	_____ Date Signed	_____ Signature
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