

**Election of Portable Coverage Form For Group Life  
and Accidental Death & Dismemberment (AD&D) Insurance Coverage**

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*Important Information About MetLife's Portability Option*

You're in a time of transition, and MetLife welcomes the opportunity to provide you and your dependents with an affordable option to continue the Group Life Insurance coverage or Group Life and Accidental Death & Dismemberment Insurance coverage that you had with your former plan.

Here are some highlights of your Portability option...

- **You can take coverage with you.** You may continue the same or lesser amount of life insurance coverage you had on yourself and your dependents at the time of your coverage termination through your former plan (See Part A of the Election Form). The minimum amount an employee can continue on a portable basis is \$20,000; the maximum is generally equal to the Life insurance coverage amount at the time of coverage termination or \$1,000,000, whichever is less.
- **Full protection for you and your family.** When you elect portable coverage, you will have these valuable features: MetLife's Total Control Account<sup>®</sup> (TCA) for you and your dependent(s) and Accelerated Benefits Option (ABO) for you and your dependent spouse.

It's easy to elect Portable coverage:

1. Complete the attached Election Form **within 31 days** from the date your benefits are terminated or reduced, 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 or reduced.
2. Select the portable coverage amount for you and your dependents (see attached Election Form Part B).
3. Designate your beneficiary(ies) and provide the required signatures.
4. **Send your completed Election Form to: MetLife Recordkeeping Center, P. O. Box 6169, Utica, NY 13504-6169.**
5. Upon receipt of your completed Election Form, MetLife will send your initial monthly bill directly to your home address.

If you have any questions, require assistance in completing your Election Form, or wish to find out the cost of your portable coverage, you may phone our MetLife Recordkeeping Center toll-free at 1-866-492-6983, between the hours of 8:00 a.m. and 5:00 p.m. (EST).

**ELECTION OF PORTABLE COVERAGE FORM**

**Instructions to Employer:**

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 EMPLOYER**

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Employer To Verify Insurance Amount(s) In Effect At Termination Date:</b>				
<b><u>METLIFE INSURED COVERAGE AMOUNTS IN EFFECT:</u></b>				
<b>Insured:</b>	<u>Life Insurance Amount</u>	<u>AD&amp;D Insurance Amount</u>		
• Basic Life	\$ _____	Not Applicable		
• Basic Life/AD&D	\$ _____	\$ _____		
• Optional Life	\$ _____	Not Applicable		
• Optional Life/AD&D	\$ _____	\$ _____		
<b>Dependent Spouse:</b>				
• Dependent Life	\$ _____	Not Applicable		
• Dependent Life/AD&D	\$ _____	\$ _____		
<b>Dependent Chil(dren):</b>				
• Dependent Life	\$ _____	Not Applicable		
• Dependent Life/AD&D	\$ _____	\$ _____		

**ELECTION OF PORTABLE COVERAGE FORM (Continued)**

If you are a resident of Minnesota, Oregon, South Dakota or Vermont, Portable Term coverage is not available to you. If you are a resident of the state of Michigan, the maximum amount of coverage you are allowed to port is \$149,000.

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 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**

<p><b>Insured Application Period:</b> The Insured must apply for portable coverage within 31 days from the date benefits were terminated or reduced, 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 or reduced.</p>	<p>You may continue coverage at the same amount you had at the time of coverage termination or at a lesser amount. The 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%.</p>
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**Portable Insurance Amount(s) Requested (Please Round Coverage to the nearest thousand)**

	<u>Same Amount</u>	<u>Decreased Amount</u> <sup>1</sup>	<u>No Coverage</u>
<b>Insured:<sup>2</sup></b>			
• Basic Life	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
• Basic Life/AD&D <sup>3</sup>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
• Optional Life	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
• Optional Life/AD&D <sup>3</sup>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
<b>Dependent Spouse:<sup>4</sup></b>			
• Dependent Life	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
• Dependent Life/AD&D <sup>3</sup>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
<b>Dependent Child(ren):<sup>4</sup></b>			
• Dependent Life	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>
• Dependent Life/AD&D <sup>3</sup>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>

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

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attach a separate sheet of paper, signed and dated)

	Date of Birth (Mo./Day/Yr.)	Social Security No.
Spouse: _____	_____	_____
Child(ren): _____	_____	_____
_____	_____	_____
_____	_____	_____

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.
3. AD&D amount selected will be equal to the Life Insurance amount and must be in effect at time of termination. AD&D coverage is not available without Life Insurance coverage.
4. In order to elect Portable coverage for your dependent(s), if applicable, you must elect coverage for yourself. The amount of coverage elected must not exceed the amount elected for yourself.

ENHANCED-EPORT

Please Retain A Copy Of The Fully-Completed Form For Your  
Records And Return The Original To MetLife Recordkeeping Center  
If you have any questions, please call 1-866-492-6983  
(Continued on Following Page)

T7000 (03/02)

**ELECTION OF PORTABLE COVERAGE FORM (Continued)**

**TO BE COMPLETED BY THE INSURED (Continued)**

DESIGNATION OF BENEFICIARY FOR INSURED LIFE BENEFITS (The Dependent Life Benefits are Payable to the Insured)				
<input type="checkbox"/> I Designate as my Primary Beneficiary: <input type="checkbox"/> 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.

**Kansas and 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.

**Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement may have violated state law.

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 is a crime and subjects such person to criminal and civil penalties.

Insured/Assignee Signature:	Date:
Dependent Spouse Signature:	Date:
Dependent Child Signature (if over 18 years of age and/or a Michigan Resident):	Date: