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 six 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

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:		**Discounted ABO Provision:**	
Your current coverage:	$50,000	Your current coverage:	$50,000
Amount accelerated:	-25,000	Amount accelerated:	-25,000
Net accelerated payment:	$25,000	8% mortality and interest charge (25,000 x .08):	-2,000
		Net accelerated payment:	$23,000
Remaining Group Life Insurance Payable to Your Beneficiary:	$25,000	Remaining Group Life Insurance Payable to Your Beneficiary:	$25,000

ACCELERATED BENEFITS CLAIM FORM
Claimant's Statement

MetLife®

Metropolitan Life Insurance Company
Group Life Claims Division
P.O. Box 6068
Utica, NY 13504-6068
Telephone Number: 1-800-638-6420

Please complete this form and return it to your Employer.

1. Employee's Name _____
   Last First Middle

   Employee's Soc. Sec. No. | | | | | | | | | Employee's Date of Birth Mo. Day Yr. Sex ☐ Male ☐ Female

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:

   _____ | | | | | | | | | Mo. Day Yr. Sex ☐ Male ☐ Female
   Name Social Security Number. Date of Birth

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

6. Select the coverage and amount you wish to accelerate. The minimum claim amount is $5,000.
   ☐ Group Universal Life Insurance $ _____

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

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

The covered employee must sign for all claims.

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

I declare that the above information is correct.

If you are insured under a policy issued in one of the following states, or if you reside in one of the following states, one of the following state warnings may apply to you:

New York [only applies to Accident and Health Benefits (AD&D/VAD&D)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

Florida: 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 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 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information 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, Washington and Vermont: 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 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: 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.

All other states:

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.

_____ _____
Employee Signature Date

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

Statement of Attending Physician

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

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:

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

K. Past, present and future course of treatment:

L. Other known injuries or presently active diseases:

M. 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 _____

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 6 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 | Signature

Statement of Attending Physician (Continued)

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, P.O. Box 6068, Utica, NY 13504-6068

Social Security Number	Name of Covered Employee Last First Middle	Date of Birth Mo. Day Yr.	Sex M F

Name of Employer **BP**

Division or Subsidiary and Location **95520**

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 six months from date of claim.
			☐ Group Universal Life		

Complete the Following:

Employee is ☐Hourly ☐Salaried

☐Retired ☐Union ☐Non-Union

☐Exempt ☐Non-Exempt

Base Annual Earnings $_____

As of Date: Mo. Day Yr.

Please Complete Information Below:

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

☐ Retired Employee: 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 for stopping _____

Was the employer-employee relationship terminated before accelerated benefits were claimed?

☐ No ☐ Yes Date Mo. Day Yr.

Reason _____

Was life insurance cancelled? ☐ No ☐ Yes Date Mo. Day Yr.

Employer's Authorized Representative:

Name _____ Title _____ Phone # _____

Signature _____ Date _____