MetLife®
Metropolitan Life Insurance Company, New York, NY

Notice of Group Life Insurance Conversion Privilege

INSTRUCTIONS TO POLICYHOLDER/RECORDKEEPER: Complete this Notice and provide a copy to the employee when group coverage terminates or reduces. If coverage has been assigned, provide notice to the Assignee. If an Accelerated Benefits Option claim was paid, show the remaining amount of coverage following payment. Fax a file copy of this Notice to MetLife at 1-888-422-4272, or send via e-mail to solutions@metlife.com.

INSTRUCTIONS TO ELIGIBLE PERSON: Upon termination or reduction of group insurance, you may convert your coverage to an individual life insurance policy, which will be issued without medical examination if you apply for it and pay the required premium within the application period.

APPLICATION PERIOD: The application period is based on the date your group coverage terminates and the date of this Notice. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if this Notice is dated more than 15 days from date of termination, your application period is extended for an additional 15 days. If the 15-day extension applies to you, it will not exceed more than 91 days from the date group insurance was terminated.

The conversion application period is time-sensitive. If you are interested in converting your group coverage, you must meet with a licensed MetLife Financial Services Representative and complete an application. Call 1-877-ASKMET7 (1-877-275-6387) or e-mail solutions@metlife.com to begin this process. Please provide a copy of this Notice to the representative when you meet. If your application is approved, the individual policy will be issued on the 32nd day following termination of group coverage, regardless of the date of application.

This Notice is not a conversion application or policy

Eligible Person / Employee Information

Date of this Notice / /	Date Group Coverage terminates or reduces: / / .		
Name of Insured (Last, First, MI)	Relationship to Employee ☐ Self ☐ Dependent	☐ Male ☐ Female	Date of Birth / /
Name of Owner if Certificate is Assigned (Last, First, MI)		☐ Male ☐ Female	Date of Birth / /
Dependent Name, if applicable (Last, First, MI)		☐ Male ☐ Female	Date of Birth / /
Street Address of Insured/Owner City State Zip Code	Phone ( ) -	Date Group Life benefits became effective for insured / /	

Reason for termination: ☐ Termination of Employment ☐ Retirement ☐ No Longer an Eligible Dependent
☐ Termination of Group Policy or Class under Policy ☐ Total Disability

Coverage Information

Complete the relevant column based on the event triggering conversion.	If coverage is ending due to termination of employment or eligibility, or is reducing, complete the applicable fields below.	If the group policy or a class under the policy is ending, complete the applicable fields below. The amount of coverage available for conversion is the lesser of the amount lost, or $10,000, provided the insured was covered under the plan for at least five years.

Coverage Type	Group Policy Report Number	Coverage Amount	Coverage Amount , if less than $10,000
Basic Life		$	$
Supplemental Life		$	$
Dependent Spouse Life		$	$
Dependent Child Life		$	$
Group Universal Life		$	$
Survivor		$	$

Group Policyholder Name	Group Policyholder Address & Phone No. ( ) -
Authorized Group Policyholder Representative (Print)	Signature of Authorized Group Policyholder Representative Date / /