

# Conversion of Group Life Benefits to an Individual Policy

|   |  |                                       |   |                                     |  |                   |
|---|--|---------------------------------------|---|-------------------------------------|--|-------------------|
| <b>Part A – Conversion Privilege Notice To Eligible Person</b>  |  |                                       |   | Date of this notice / /             |  |                   |
| <p><b>To The Employee/Assignee:</b> The Group Term Life benefits in the amount(s) indicated below will be terminated on (Date) _____</p> <p>You may apply for an Individual Life Insurance policy (other than Term Insurance), which will be issued without medical examination by Metropolitan Life Insurance Company (hereafter "MetLife"), if you apply for it and the required premium payment is made within:</p> <ul style="list-style-type: none"> <li>• <b>31 days from the date benefits were terminated, or</b></li> <li>• <b>15 days from the date this notice is given, if notice is given more than 15 days from the date benefits were terminated.</b></li> </ul> <p><b>In no event will this period extend beyond 91 days from the date benefits were terminated.</b></p> <p>Use one of the methods shown below to contact MetLife to apply for an individual policy. We will arrange for a Financial Services Representative to follow-up with you and assist you in the application process.</p> <ul style="list-style-type: none"> <li>• <b>Call MetLife's toll-free number 1-877-ASK MET7 (1-877-275-6387), or</b></li> <li>• <b>Contact us via the Internet at solutions@metlife.com</b></li> </ul> |  |                                       |   |                                     |  |                   |
| Name of Insured (Last, First)   |  | Relationship to Employee              | <input type="checkbox"/> Self<br><input type="checkbox"/> Dependent | Male<br>Female                      | <input type="checkbox"/><br><input type="checkbox"/> | Date of Birth / / |
| Name of Owner if Certificate is Assigned (Last, First)  |  |                                       | Amount(s) of Group Life benefits that may be converted.             |                                     |  |                   |
| Address of Insured/Owner Street   |  |                                       | \$ _____ Basic Life Experience # _____                              |                                     |  |                   |
| City State Zip Code   |  |                                       | \$ _____ Optional Life Experience # _____                           |                                     |  |                   |
|   |  |                                       | \$ _____ Spouse Life Experience # _____                             |                                     |  |                   |
|   |  |                                       | \$ _____ Child Life Experience # _____                              |                                     |  |                   |
|   |  |                                       | \$ _____ Survivor Experience # _____                                |                                     |  |                   |
| Name of Employee, if other than insured   |  | Employee's Social Security Number / / |   | Telephone (Include Area Code) ( ) - |  |                   |
|   |  |                                       |   | Job Title                           |  |                   |

|  |  |                         |   |                        |                                   |
|--|--|-------------------------|---|------------------------|-----------------------------------|
| <b>Part B – Employer Information To MetLife</b>  |  |                         |   |                        |                                   |
| Date Group Life benefits became effective for insured / /  |  |                         | Reason for termination of Group Life benefits:  |                        |                                   |
|  |  |                         | <input type="checkbox"/> Termination of Employment <input type="checkbox"/> No Longer an Eligible Dependent<br><input type="checkbox"/> Retirement <input type="checkbox"/> Termination of Group Policy |                        |                                   |
| Was an ABO claim paid? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                         | If yes, what is the claim amount? \$ _____  |                        |                                   |
|  |  |                         | Subtract this amount from amount(s) in force prior to discontinuance.   |                        |                                   |
| Amount(s) in force prior to discontinuance:  |  | Amount(s) discontinued: |   | Amount(s) continued:   |                                   |
| \$ _____ Basic Life  |  | \$ _____ Basic Life     |   | \$ _____ Basic Life    |                                   |
| \$ _____ Optional Life   |  | \$ _____ Optional Life  |   | \$ _____ Optional Life |                                   |
| \$ _____ Spouse Life   |  | \$ _____ Spouse Life    |   | \$ _____ Spouse Life   |                                   |
| \$ _____ Child Life  |  | \$ _____ Child Life     |   | \$ _____ Child Life    |                                   |
| \$ _____ Survivor  |  | \$ _____ Survivor       |   | \$ _____ Survivor      |                                   |
| Was the employee totally disabled on the date the benefits were discontinued? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                         |   |                        |                                   |
| Name of Employer   |  |                         |   |                        |                                   |
| Address Street   |  | City                    |   | State Zip Code         |                                   |
| Signed   |  |                         | Date / /  |                        | Telephone Include Area Code ( ) - |

|  |  |                              |  |   |  |
|--|--|------------------------------|--|---|--|
| <b>For Use Only By MetLife</b>   |  |                              |  |   |  |
| <b>To Be Completed By Group Department</b>   |  |                              |  |   |  |
| <input type="checkbox"/> Issue a conversion policy in an amount up to \$ _____. <input type="checkbox"/> Decline issue – conversion period expired.<br>Person <b>is not</b> eligible for term insurance. <input type="checkbox"/> Decline issue – 5 year Group coverage requirement not met. |  |                              |  |   |  |
| Are the Experience Number(s) indicated above correct? <input type="checkbox"/> Yes <input type="checkbox"/> No      If "No," correct the Experience Number(s) shown above.   |  |                              |  |   |  |
| Approval to issue or decline furnished by Signature  |  | Reg. Bus. Unit/Nat'l. Accts. |  | Telephone Include area code ( ) -                         |  |
|  |  |                              |  | Date / /  |  |
| <b>To Be Completed By Individual Business</b>  |  |                              |  |   |  |
| Type of Policy Issued: <input type="checkbox"/> Life Paid-up at 98 <input type="checkbox"/> Universal Life   |  | Amount of Policy \$ _____    |  | Effective Date of Policy / /                              |  |
| Policy Number  |  | Completed by Signature       |  | IB NB Processing Center Telephone Include area code ( ) - |  |
|  |  |                              |  | Date / /  |  |

- Instructions to Employer**
1. Complete both Parts A and B above **immediately** upon termination of Group Life benefits for an eligible employee and/or covered dependents.
  2. Make copies of the completed form and give the original copy to the person eligible to convert or mail it to the last known address.
  3. Mail a copy of the completed form to the MetLife office responsible for administering your Group contract.
  4. Send a copy of the form via fax (1-888-422-4272) or Internet (solutions@metlife.com) to the ESS Resource Center.