

# Notice of Group Life Insurance Conversion Privilege

Metropolitan Life Insurance Company

*This Notice is not a conversion application or policy*

## Instructions

### 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.

### Instructions to Eligible Person:

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 can meet with a specially-trained financial professional and complete an application. MetLife has an arrangement for third party financial professionals to explain your options. Call us at 877-275-6387 to arrange for a third party financial professional to contact you directly.

## Eligible Person / Employee Information

Date of This Notice *(mm/dd/yyyy)* | Date Group Coverage Terminates or Reduces *(mm/dd/yyyy)*

### ► Insured

First Name	Middle Name	Last Name
Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Dependent	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <i>(mm/dd/yyyy)</i>

### ► Owner *(If certificate is assigned)*

First Name	Middle Name	Last Name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <i>(mm/dd/yyyy)</i>	

### ► Dependent *(If applicable)*

First Name	Middle Name	Last Name	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <i>(mm/dd/yyyy)</i>		
Address	City	State	ZIP

Phone Number

Date Group Life Benefits Became Effective for Insured (mm/dd/yyyy)

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

**Coverage Information**

Complete the relevant column based on the event triggering conversion.  
If an accelerated benefits option claim was paid, reduce the amount available for conversion by the ABO claim amount.

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. Cannot Exceed \$10,000
Basic Life			
Supplemental Life			
Dependent Spouse Life			
Dependent Child Life			
Group Universal Life			
Group Variable Universal Life			
Survivor			

**Group Policyholder**

Name

Address	City	State	ZIP
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Phone Number

**Authorized Group Policyholder Representative (Print)**

First Name	Last Name
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