


Group Term Life Insurance Beneficiary Designation

Metropolitan Life Insurance Company

Things to Know Before You Begin

- This form **MUST** be signed before you return it. See "SECTION 3 - Signature" on page 3.

 You **MUST** return all pages of this form.

Utility Field 1	Utility Field 2	Utility Field 3	Utility Field 4
-----------------	-----------------	-----------------	-----------------

SECTION 1: Insured Information

Customer Number		Policyholder Name/Group Policyholder Name		
First Name	Middle Name	Last Name		
Address - Street		City	State	ZIP Code
Date of Birth (<i>mm/dd/yyyy</i>)	Phone Number	Social Security Number		

SECTION 2: Beneficiary Information

- You **MUST** designate at least one primary beneficiary. **A person may only be listed once.** Anyone listed in the primary section cannot be listed in the contingent section.
- The sum of the Primary Beneficiary percentages **MUST equal 100%**. The sum of the Contingent Beneficiary percentages **MUST equal 100%**. Dollar amounts, fractions and decimals will not be accepted.
- If you need more Space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

Please complete the section that pertains to the type of beneficiary you are designating.

A. Individual Beneficiaries

Primary Beneficiary - Your first choice to receive your life insurance proceeds in the event of your death. If any primary beneficiaries predecease you, that person's share will be equally divided among any remaining primary beneficiaries.

First Name	Middle Name	Last Name	Share %	
Address - Street		City	State	ZIP Code
Relationship to Participant	Social Security Number	Date of Birth (<i>mm/dd/yyyy</i>)	Phone Number	

First Name	Middle Name	Last Name	Share %	
Address - Street		City	State	ZIP Code
Relationship to Participant	Social Security Number	Date of Birth (mm/dd/yyyy)	Phone Number	

First Name	Middle Name	Last Name	Share %	
Address - Street		City	State	ZIP Code
Relationship to Participant	Social Security Number	Date of Birth (mm/dd/yyyy)	Phone Number	

Contingent Beneficiary - Your second choice to receive your life insurance proceeds if ALL of your primary beneficiary(ies) are not living at the time of your death. If any contingent beneficiaries predecease you, that person's share will be equally divided among any remaining contingent beneficiaries.

First Name	Middle Name	Last Name	Share %	
Address - Street		City	State	ZIP Code
Relationship to Participant	Social Security Number	Date of Birth (mm/dd/yyyy)	Phone Number	

First Name	Middle Name	Last Name	Share %	
Address - Street		City	State	ZIP Code
Relationship to Participant	Social Security Number	Date of Birth (mm/dd/yyyy)	Phone Number	

B. Living Trust - Primary Contingent

If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.

Trust Name	Trust Date (mm/dd/yyyy)	Trustee Phone Number	Share %	
Trustee - First Name	Middle Name	Last Name		
Trustee Address - Street		City	State	ZIP Code

C. Testamentary Trust Created in the Insured's Will - Primary Contingent Share %
 The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

D. Insured's Estate - Primary Contingent

Share %

If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named.

E. Charity/Organization - Primary Contingent

Be sure to name the charity or organization and not the charity or organization director or an participant of that charity/organization.

Charity/Organization Name

Phone Number

Share %

Address - Street

City

State

ZIP Code

SECTION 3: Signature

Check if you are completing and signing this form as agent for the participant under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.

I hereby revoke any previous designations, and I designate the person, people, or entity named in Section 2 as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured/Owner Name *(Please print)*

First Name

Middle Name

Last Name

**Sign
Here**

Signature of Insured/Owner

Date *(mm/dd/yyyy)* *(must be date form was completed)*

SECTION 4: How to Submit This Form

The member should provide the completed form to the National Association for the Self-Employed. Retain a copy for your records.

Mail:

National Association for the Self-Employed
P.O.Box 241
Annapolis Jct., MD 20701-0241

For Assistance Please Call:

1-800-649-6273

Fax to the NASE:

1-800-678-4605