

Notice of Group Life Insurance Conversion Privilege

Metropolitan Life Insurance Company, New York, NY

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. 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 25 days. If the 25-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 licensed financial professional and complete an application. MetLife has an exclusive arrangement for financial professionals from Massachusetts Mutual Life Insurance Company (*MassMutual*) to explain your options. Call us at 877-275-6387 to arrange for a local MassMutual financial professional to contact you directly, usually within 48 hours of your request.

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 (mm/dd/yyyy)

► Owner *If certificate is assigned*

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

► Dependent *If applicable*

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

Address	City	State	ZIP
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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

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

Phone number

Authorized Group Policyholder representative (print)

First name

Last name