

Change of Beneficiary By Insured

Use this form only if the Insured is the Policyowner.

Do not use this form for a Joint Life Policy, Survivorship Whole Life Policy, or to change the beneficiary of a rider.

Please Print or Type Information.



Customer Service Center

Policy Number(s) _____

Insured _____

Has your name changed? If so, check reason: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Correction <input type="checkbox"/> Naturalization <input type="checkbox"/> Court Order					
Print new name: _____					
(Prefix)	(First)	(Middle)	(Last)	(Suffix)	

IMPORTANT NOTE: If any Beneficiary or Contingent Beneficiary is a minor at the time of the Insured's death, MetLife may not be able to make payment until a guardian of the estate of the minor has been appointed.

I revoke any previous designation of Beneficiary and Contingent Beneficiary under the above policy and any previous election of an optional mode of settlement (optional income plan) that applies to any amount payable under the policy in the event of my death.

A. I name the following **Revocable Beneficiary(ies)** to receive any amount payable under the policy in the event of my death:

Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						

If you wish to designate more than 4 Revocable Beneficiaries, contact the MetLife Beneficiary & Ownership Unit for a form which can be used to accommodate this request.

Initial form here and sign on last page → _____
Insured's Initials Date

Policy Number(s) _____ Insured _____

B. If all the Beneficiaries named above shall predecease me, I name the following **Revocable Contingent Beneficiary(ies)** to receive any amount payable under the policy in the event of my death:

Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						
Individual's Name	Prefix	First	Middle	Last	Suffix	Share % (Leave blank for equal distribution)
Date of Birth	/	/	SSN/EIN	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insured
<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory Country	
Home Phone ()			E-Mail Address		Country of Citizenship	
Business Phone & Ext. ()						

If you wish to designate more than 5 Revocable Contingent Beneficiaries, contact the MetLife Beneficiary & Ownership Unit for a form which can be used to accommodate this request.

Initial form here and sign on last page → _____ Insured's Initials _____ Date

Policy Number(s) _____ Insured _____

C. Check box **only** if the current spouse of the Insured is named as beneficiary in **Section A** (above) and all children (present and future) born of the marriage of the Insured and said spouse are to be included as contingent beneficiaries. If so, the names, addresses and dates of birth of all existing children are to be listed in **Section B (above)**. Any child not born of the marriage of the Insured and said spouse, who is to be included as contingent beneficiary, **must be named in Section B**.

I agree that any decision MetLife makes in determining unnamed contingent beneficiaries based upon written evidence acceptable to MetLife, will be final.

If multiple Beneficiaries or Contingent Beneficiaries are named above, payment will be made in equal shares or all to the survivor, unless otherwise specified. If box C (above) is checked, the shares of all contingent beneficiaries shall be equal. The share of any Beneficiary or Contingent Beneficiary who shall predecease me will be divided among the surviving beneficiaries in proportion to their interest, with all to the survivor. If there is no survivor, then payment shall be made to my estate.

Any payment by MetLife in good faith pursuant to the foregoing designation shall fully discharge MetLife of its liability under the policy.

I understand that this change shall be binding on MetLife only after it has been recorded and filed in the MetLife Home Office or Customer Service Center. Once recorded, the change will be effective as of the date signed below.

I understand that some policies may provide that a change of beneficiary must be endorsed upon the policy. In completing this form, I consent and request that MetLife may in its discretion waive any such provision requiring endorsement for this and any future change. I consent and request that if the policy does not contain a beneficiary provision, that MetLife may pay any amount payable upon my death in accordance with this direction.

By signing below, I certify that I have read the information on both pages of this form and that I am in agreement with it.

MetLife means the Metropolitan Life Insurance Company or any of its affiliates.

Witness: _____ Signature of Insured _____ Date _____

Print Name _____ Print Name (Prefix First Middle Last Suffix) _____

To be completed by the insured

<input type="checkbox"/> Primary Residence <input type="checkbox"/> Business <input type="checkbox"/> Mailing <input type="checkbox"/> Other	Street	City	State	Zip Code	If Foreign: Province/Territory	Country
Home Phone ()	E-Mail Address			Country of Citizenship		
Business Phone & Ext. ()						

Submitting Sales Office/Number/Agency