MetLife

Accidental Death & Dismemberment (AD&D) Beneficiary Designation

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

SECTION I - Insured Information

Customer Number
1137000

Employer Name/Group Policyholder Name
Citi

First Name | Middle Name | Last Name

Address – Street | City | State | ZIP Code

Date of Birth | Phone Number | SSN **- OR -** Employee ID Number

SECTION II - Plan Information

I elect that the beneficiary designation shown on this form apply only to the plan insured by MetLife indicated below:

- Supplemental Accidental Death & Dismemberment

SECTION III - 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 Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee	Social Security Number	Date of Birth	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 Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee / Social Security Number		Date of Birth	Phone Number	

First Name	Middle Initial	Last Name		**Share: %**
Address – Street	City	State	ZIP Code	
Relationship to Employee / Social Security Number		Date of Birth	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	Trustee Phone Number	**Share: %**
Trustee - First Name	Middle Initial	Last Name		
Trustee Address – Street	City	State	ZIP Code	

☐ C. Testamentary Trust Created in the Insured's Will – ☐ Primary ☐ Contingent

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

Share: %

☐ D. Insured's Estate – ☐ Primary ☐ Contingent

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 employee of that charity/organization.

Charity/Organization Name		Phone Number		**Share: %**
Address – Street	City	State	ZIP Code	

SECTION IV - Signature

☐ Check if you are completing and signing this form as agent for the employee 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 III as Beneficiary(ies). I reserve the right to change or revoke this designation at any time.

Insured/Owner Name (Please Print)

_____

Insured/Owner Signature

Date (must be date form was completed)

▶ _____ _____

How to Submit This Form

Return this signed and completed form to the address below. Retain a copy for your records.

Mailing Address: MetLife Record Keeping Center, P.O. Box 14401, Lexington, KY 40512-4401

Phone Number: 888-830-7380

Please note: You MUST return all pages of this form.