MetLife
Attn: Expatriate Benefits
600 King Street
Wilmington DE, 19801 USA
Toll Free (Within U.S.): 1-800-451-1847
Direct: +1-302-661-8674
Fax: +1-302-427-0817
Email: wilmclaims.metlifeexpat@alico.com
www.metlifeexpat.com

DEATH CLAIM FORM - GROUP LIFE INSURANCE

By furnishing this blank and investigating the claim the Company shall not be held to admit the validity of any claim or to waive the breach of any condition of the policy.

TO BE COMPLETED IN FULL BY POLICYHOLDER

Name of Insured (Policyholder) ______ Address ______

Name of Deceased ______ Address ______

Group No. ______ Certificate No. ______ Class ______ Date of Birth ______ Date of Death ______

Date Employed ______ Annual Income ______ Date Last Worked ______ Date Terminated ______

Date Insured ______ Last Change in Benefit - From: ______ To. ______ Date Changed ______

Cause of Death ______ Occupation ______

IF THIS IS A UNION OR TRUSTEE PLAN: Date Became a Member ______ Date Terminated Memership ______

Was Member in good standing at date of death? ☐ Yes ☐ No

Is deceased eligible for benefits under the Health and Welfare Trust Fund? ☐ Yes ☐ No

Signature of Policyholder Representative: ______ Title ______ Date ______

Mail Check to: ______

TO BE COMPLETED BY BENEFICIARY

(if Beneficiary is a minor or mentally incompetent person, the parent or guardian of the beneficiary should complete this section)

Name of Beneficiary ______ Address ______

Date of Birth ______ Relationship to Deceased ______ Telephone Number (DAY) ______

The undersigned hereby makes claim to said insurance in the Company and agrees that the written statements and affidavits of all the physicians who attended or treated the Insured, and all other papers called for shall constitute and are hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form or any other forms supplement thereto, by the Company shall not constitute nor be considered an admission by it that there was any insurance in force on the life in question, nor a waiver of its rights or defenses.

The undersigned hereby authorizes all physicians, hospitals, druggists and employees to disclose to the Insurance Company names above or its representative, any and all information with respect to medical history, consultation, prescription or treatments and copies of all hospital or medical records of ___________________, deceased.

I understand that this authorization is valid for the duration of this claim and that a photocopy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization. I certify that the above information is true and correct to the best of my knowledge and belief.

Signed: ______ Date ______ Witness: ______

Coverage is underwritten by Delaware American Life Insurance Company

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HOW TO FILE A CLAIM

Each beneficiary named by the participant on the beneficiary designation form must complete a Death Claim Form. The signature of the beneficiary must be witnessed.

Forms should be completed in detail and should include verification from the employer as to the last date worked. If the participant was not actively at work at the time of death, the reason for the cessation of employment must be provided. (This is not applicable for dependent life insurance benefits.) If the participant was not working due to ill health, physician's statements may be required.

The following should be attached to the claim form:

* A certified copy of the original death certificate
* The most recent beneficiary designation form

Guardianship papers must be provided if the beneficiary is a minor child.

The following statement is applicable to California claimants:
For your protection, California law requires the following to appear on this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

The following statement is applicable to New York claimants:
Any person who knowingly and with intent to defraud any insurance company or other person files anapplication for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed
five thousand dollars and the stated value of the claim for each such violation.

The following statement is applicable to Pennsylvania claimants:
Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent instance act,
which is a crime and subjects such person to criminal and civil penalties.

The following is applicable to all other states:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or
knowingly presents false information in an application for insurance is guilty of a crime and may be
subject to fines and confinement in prison.

Coverage is underwritten by Delaware American Life Insurance Company