MetLife

Group Term Life Insurance Beneficiary Designation

• This form **MUST** be signed before you return it. See "SECTION III – Signature" on page 4.

SECTION I - Insured Inform	mation						
Customer Number 109929		Employer Name/Group Policyholder Name Harvard University					
First Name		Middle Name		Last Nar	ne		
Address – Street	(City		State		ZIP Code	
Date of Birth	(Phone Number	HUID		DID		
You MUST designate at least on Anyone listed in the primary sect The sum of the Primary Beneficial	ne primary bend tion cannot be ary percentage	neficiary for <u>each</u> con listed in the conting es MUST equal 10 0	gent section. 0% . The sum of th				
100%. Dollar amounts, fractionsIf you need more space for additi	and decimals	will not be accepted	d.				-
Please complete each cover		<u> </u>					
BASIC LIFE - Beneficiary	. Designat	ion					
I elect that the beneficiary design	_		ies to the Basic	: Life plans	insured	by MetLife:	
A. Individual Beneficia	aries					•	
PRIMARY BENEFICIARY - Y beneficiaries predecease you, tha	our first choic						iny primary
First Name	First Name		Last Name	T		Share:	
Address - Street		City			State	ZIP Code	
Relationship to Employee	Social Secu	rity Number	Date of Birth	j (Phone Number ()		
First Name Middle Initi		Middle Initial	Last Name			Share:	
		C:t.			State	ZID Codo	%
Address – Street		City			State	ZIP Code	
Relationship to Employee	Social Secu	rity Number	Date of Birth Phone Number ()		mber	-	
First Name		Middle Initial	Last Name			Share:	

Address - Street

Relationship to Employee

Date of Birth

City

Social Security Number

ZIP Code

State

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:

First Name		Middle Initial	Last Name			Share:		
Address – Street		City	I	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by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.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. <u>Testamentary Trust Created in the Insured's Will</u> – ☐ 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. <u>Charity/Organization</u> Description Description								
Charity/Organization Name				Phone Nu	mber	Share:		
Address – Street		City		State	ZIP Code	, ,		

SUPPLEMENTAL/OPTIONAL LIFE - Beneficiary Designation								
I elect that the beneficiary designetLife:	gnation indica	ted below applie	es to the Supplemental	Optional L	ife plans insured b	у		
A. Individual Beneficia	<u>aries</u>							
PRIMARY BENEFICIARY - Y beneficiaries predecease you, that						ny primary		
First Name		Middle Initial	iddle Initial Last Name					
Address - Street		City		State	ZIP Code	%		
Relationship to Employee	Social Securit	y Number	Date of Birth	Phone Nu	 mber			
First Name		Middle Initial	Last Name			Share:		
			23011130			%		
Address – Street		City		State	ZIP Code			
Relationship to Employee	Social Securit	y Number	Date of Birth	Phone Number ()				
First Name		Middle Initial	Last Name			Share: %		
First Name Address – Street		Middle Initial City	Last Name	State	ZIP Code			
	Social Securit	City	Last Name Date of Birth	State Phone Nu				
Address - Street	f - Your seconeath. If any conf	City y Number d choice to receiv	Date of Birth e your life insurance proc	Phone Nu	mber of your primary bene	% eficiary(ies)		
Address – Street Relationship to Employee CONTINGENT BENEFICIAR are not living at the time of your determined to the street of	f - Your seconeath. If any conf	City y Number d choice to receiv	Date of Birth e your life insurance proc	Phone Nu	mber of your primary bene	% eficiary(ies)		
Address – Street Relationship to Employee CONTINGENT BENEFICIARY are not living at the time of your deany remaining contingent beneficial	f - Your seconeath. If any conf	City y Number d choice to receivingent beneficiario	Date of Birth re your life insurance proces predecease you, that p	Phone Nu	mber of your primary bene	% eficiary(ies) ded among Share:		
Address – Street Relationship to Employee CONTINGENT BENEFICIAR are not living at the time of your de any remaining contingent beneficial First Name	f - Your seconeath. If any conf	City y Number d choice to receive ingent beneficiarie Middle Initial City	Date of Birth re your life insurance proces predecease you, that p	Phone Nu () eeds if ALL erson's sha	mber of your primary benere will be equally divided	% eficiary(ies) ded among Share:		
Address – Street Relationship to Employee CONTINGENT BENEFICIARY are not living at the time of your de any remaining contingent beneficiary First Name Address – Street Relationship to Employee	f - Your seconeath. If any contaries.	City y Number d choice to receive ingent beneficiarie Middle Initial City y Number	Date of Birth re your life insurance proces predecease you, that p Last Name Date of Birth	Phone Nu () eeds if ALL erson's sha	mber of your primary benere will be equally divided	% eficiary(ies) ded among Share: %		
Address – Street Relationship to Employee CONTINGENT BENEFICIARY are not living at the time of your de any remaining contingent beneficial First Name Address – Street Relationship to Employee First Name	f - Your seconeath. If any contaries.	City y Number d choice to receive ingent beneficiarie Middle Initial City y Number	Date of Birth e your life insurance proces predecease you, that p	Phone Nu () eeds if ALL erson's sha State Phone Nu ()	mber of your primary benere will be equally divid	% eficiary(ies) ded among Share:		
Address – Street Relationship to Employee CONTINGENT BENEFICIARY are not living at the time of your de any remaining contingent beneficiary First Name Address – Street Relationship to Employee	f - Your seconeath. If any contaries.	City y Number d choice to receive ingent beneficiarie Middle Initial City y Number	Date of Birth re your life insurance proces predecease you, that p Last Name Date of Birth	Phone Nu () eeds if ALL erson's sha	mber of your primary benere will be equally divided	% eficiary(ies) ded among Share: %		

■ B. Living Trust – □ Primary □ If this form is executed by the insured, it is und has been revoked or is not in effect at the insure this form.	erstood and agre	eed that if MetLife receive eneficiary shall be the insu	es satisfacto ired's Estate	ry proof that the afor e, unless otherwise in	esaid trust idicated on		
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 The trust(ee) under any last Will and Testar			• —	Contingent			
					Share:		
D. Insured's Estate − □ Primary If the Insured's Estate is selected as the Primary □ E. Charity/Organization − □ Pr Be sure to name the charity or organization and	Beneficiary, no C	Contingent Beneficiary ma			ization.		
Charity/Organization Name			Phone Nu	ımber	Share:		
Address – Street	City		State	ZIP Code	70		
SECTION III - 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 II 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							
The employee should provide the complete	d form to their E	Employer. Retain a cop	y for your	records.			
Mailing Address: Benefits Office, 114 Mou	ınt Auburn Stree	et 4th Floor, Cambridge	e, MA 0213	8			
Please note: \	ou MUST r	eturn all pages o	f this fo	rm.			