



SCMEBF Designation of Beneficiary Form

Metlife Life Insurance Benefits (Active \$50,000*)

Please PRINT clearly:

NAME: _____ SSN: _____

HOME ADDRESS: _____ FORMER NAME: _____

CITY, STATE: _____ DATE OF BIRTH: _____

MEMBER'S SIGNATURE

DATE

I hereby name the following BENEFICIARY(S) to receive the MetLife Life Insurance Benefit, payable on my behalf. I reserve the right to change the designation at any time. If the named beneficiary predeceases me, this benefit payable on my behalf shall be paid to the CONTINGENT beneficiary listed below. I reserve the right to change my designation at any time. Social security numbers of any listed beneficiary must be provided.

1. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY
CONTINGENT
(Check Only One)
CITY, STATE: _____ DATE OF BIRTH: _____ %

2. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY
CONTINGENT
(Check Only One)
CITY, STATE: _____ DATE OF BIRTH: _____ %

3. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY
CONTINGENT
(Check Only One)
CITY, STATE: _____ DATE OF BIRTH: _____ %

4. NAME: _____ SSN: _____

HOME ADDRESS: _____ RELATIONSHIP: _____ BENEFICIARY
CONTINGENT
(Check Only One)
CITY, STATE: _____ DATE OF BIRTH: _____ %

*If the active employee is over 65 years of age at time of death, the life insurance benefit is reduced by 35%. It also reduces 55% at age 70, 70% at age 75, 80% at age 80.

Sworn to before me this _____
day of _____, 20____

NOTARY PUBLIC

Please mail the completed form to:

Suffolk County Municipal Employees Benefit Fund
30 Orville Drive, Ste D
Bohemia, NY 11716-2513