SCMEBF Designation of Beneficiary Form

Metlife Life Insurance Benefits (Retiree $5,000)

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: ____________________ ________ **%**

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2. NAME: ______________________________ SSN: ______________________________

HOME ADDRESS: ______________________________ RELATIONSHIP: ____________________ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: ______________________________ DATE OF BIRTH: ____________________ ________ **%**

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3. NAME: ______________________________ SSN: ______________________________

HOME ADDRESS: ______________________________ RELATIONSHIP: ____________________ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: ______________________________ DATE OF BIRTH: ____________________ ________ **%**

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4. NAME: ______________________________ SSN: ______________________________

HOME ADDRESS: ______________________________ RELATIONSHIP: ____________________ BENEFICIARY ☐ CONTINGENT ☐ *(Check Only One)*

CITY, STATE: ______________________________ DATE OF BIRTH: ____________________ ________ **%**

Sworn to before me this __________

day of __________________, 20____

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NOTARY PUBLIC

Please mail the completed form to:

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