

SEBB Cancellation of Supplemental Life and AD&D Insurance through MetLife

Use this form to notify MetLife that you wish to cancel your supplemental life insurance or supplemental accidental death & dismemberment (AD&D) insurance. Submit this completed form directly to MetLife using the instructions below. If you later decide to enroll in coverage, you will have to provide evidence of insurability and be approved by the insurer.

Basic life insurance (\$35,000) and basic AD&D insurance (\$5,000) are not affected by this form. Basic life and AD&D are provided by your employer at no cost to you.

You cannot cancel your own supplemental life insurance and keep dependent life insurance. However, you may keep your supplemental life insurance and supplemental AD&D insurance and cancel coverage for your spouse or state-registered domestic partner and/or children.

1

Employee information

First name

Middle name

Last name

Social Security number

Date of birth

Address line 1

Address line 2

City

State

ZIP/Postal code

Phone number

Alternate phone number (optional)

2

Voluntary cancellation options

Please check the insurance coverage below you wish to cancel. Check all that apply.

Cancel supplemental life insurance for:

Me (employee)

My spouse or state-registered domestic partner

My children:

Cancel supplemental AD&D insurance for:

Me (employee)

My spouse or state-registered domestic partner

My children:



3**Cancellation due to loss of eligibility**

For dependent supplemental life insurance or AD&D insurance, subscribers must provide notice to MetLife when a dependent is no longer eligible, due to events such as divorce or a child turning age 26. MetLife may request supporting documentation verifying the eligibility change.

Reason for loss of eligibility:

Please check the insurance you need to cancel due to loss of eligibility. Check all that apply.

Cancel supplemental life insurance for:

My spouse or state-registered domestic partner

My children:

Cancel supplemental AD&D insurance for:

My spouse or state-registered domestic partner

My children:

4**Signature**

By submitting this form, I declare that the information I have provided is true, complete, and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of benefits. I understand that coverage cancellation will be effective on the first of the month following receipt of this signed and dated form, except in cases where a dependent loses eligibility, in which case the change would be processed retroactively.

I understand the information collected about me is confidential. MetLife will not release any information about me without my authorization, except to conduct business or as required or permitted by law.

Employee signature:

Date:

Do not submit this form to your employer. Make a copy for your records and submit the original form to:
MetLife Recordkeeping Center, PO Box 14406, Lexington, KY 40512-4406

WA State Health Care Authority SEBB Customer Number 219743