MetLife®

METROPOLITAN LIFE INSURANCE COMPANY
AUTHORIZATION FORM FOR
ELECTRONIC FUNDS TRANSFER OF DISABILITY PAYMENTS

INSTRUCTIONS

Submit the completed, *signed* original of this form to:

METROPOLITAN LIFE INSURANCE CO.
P. O. BOX 14590
LEXINGTON, KY 40511-4590
FAX: 1-800-230-9531

EMPLOYEE:

CLAIM #:
SOC SEC #: XXX-XX-

GROUP #: NA

GROUP NAME:

I authorize Metropolitan Life Insurance Company to send my disability payments to the Bank designated below for electronic deposit in my account. I understand that I may terminate this arrangement at any time by writing to the Metropolitan address above.

If any overpayment of such disability benefits is credited to my Account in error, I authorize and direct the bank to charge my account and to refund such overpayment to Metropolitan.

PLEASE COMPLETE THE FOLLOWING:

Type of Account (check one): Checking _____ Savings _____

Account Number: _____

Name of Bank (Print) _____

Address of Bank: _____ (Street)

_____ (City, State, Zip)

Bank telephone #: _(_____)_____

Bank Routing Number: _____

Obtain this number from your bank

Or

Attach a voided check.

_____ _____
DATE SIGNATURE