PART I — AFA VETERAN BENEFITS ASSOCIATION STATEMENT

For AFAVBA USE ONLY

Full Name of Decedent: ____________________

Effective Date of Decedent's Insurance: ____________________

Name of Beneficiary Shown on AFAVBA Records: ____________________

Relationship of Beneficiary to Insured: ____________________

Master Policy Number: ____________________ Date: ____________________

Amount of Coverage: $____________________

By: AFA Veteran Benefits Association

____

AFAVBA Authorized Staff Representative

PART II — STATEMENT OF BENEFICIARY OR OTHER CLAIMANT

Full Name of Decedent: ____________________

Date of Birth of Decedent: ____________________

Your Name: ____________________

Your Relationship to Decedent: ____________________ Your Date of Birth: ____________________

Your Address: ____________________

Street City State ZIP Code

If you are not the named beneficiary, in what capacity do you make this claim?

____

I hereby certify that, to the best of my knowledge and belief, the above statements and answers are true.

Date: ____________________

____
Beneficiary or Other Claimant

____
Witness

____
Beneficiary's Social Security #

____
Phone Number

We hereby certify that, to the best of our knowledge and belief, the above statements are correct and that said decedent's insurance was in force on the date of his or her death.

AUTHORIZATION TO RELEASE CLAIM INFORMATION TO METROPOLITAN LIFE INSURANCE COMPANY

Policy No. ____________

To any:

Physician, hospital, pharmacist, or other provider of health care services, insurer, employer, group policyholder, government agency, acquaintance, policy or benefit plan administrator:

You may give Metropolitan Life Insurance Co. information about ____________________ 's health or work status. You may also give this information on Metropolitan's behalf to: (a) the claim investigation department of a consumer reporting agency or (b) the claim department of a policy or benefit plan administrator. Health information means all information about: (1) physical or mental health condition and (2) medical treatment and supplies, if needed to evaluate this claim. This information will be used to evaluate this claim for death benefits. This form will be valid for the duration of this claim. A photocopy of this form is as valid as the original.

Date ____________ Signature ____________________

AFA VETERAN BENEFITS ASSOCIATION
METROPOLITAN LIFE INSURANCE COMPANY
LIFE INSURANCE CLAIM FORM / PROOF OF DEATH

INSTRUCTIONS FOR FILING A CLAIM/FURNISHING PROOF OF DEATH

1. Beneficiary or other claimant should complete Part II. Attach a certified copy of decedent's Death Certificate and return to AFA Veteran Benefits Association (1501 Lee Hwy., Arlington, VA 22209-1198). A staff representative will complete Part I and file with MetLife.

2. If any beneficiary, other than a contingent beneficiary, died before the Insured, a copy of the Certificate of Death of that beneficiary must be attached to the proof of death form. In that case, claim should be made by the other beneficiaries, or if there are none, by the duly appointed representative of the insured's estate.

3. If claim is made on behalf of the estate of the decedent, a certified copy of the Letters of Administration must be attached to the proof of death form.

4. If any beneficiary is a minor or adjudged legally incompetent, a certified copy of the appointment of a guardian must be attached to the proof of death form.