

INSTRUCTIONS

This form gives instructions only for 457(b) Deferred Compensation administered at www.metlife.csplans.com.

- If you have any questions, please contact your MetLife representative by calling toll-free 1-877-WITH-MET (877) 948-4638.

SECTION 1 – PARTICIPANT INFORMATION

Employer / Plan Name _____

Employer / Plan Name _____

Participant's Name (print full name) _____

Social Security Number (SSN) or
Taxpayer Identifying Number (TIN) _____

SECTION 2 – BENEFICIARY DESIGNATION

This designation revokes any previous beneficiary designation for this Plan. Unless you specify otherwise, if you designate more than one beneficiary in any one class, the beneficiaries in the class will share equally.

Primary Beneficiary(ies): *If more than two (2), attach additional sheets and check here*

(1) Name _____ Check one: Spouse non-Spouse

Social Security Number or TIN _____ Percentage _____

(2) Name _____ Check one: Spouse non-Spouse

Social Security Number or TIN _____ Percentage _____

Contingent Beneficiary(ies): *If more than two (2), attach additional sheets and check here*

(1) Name _____ Check one: Spouse non-Spouse

Social Security Number or TIN _____ Percentage _____

(2) Name _____ Check one: Spouse non-Spouse

Social Security Number or TIN _____ Percentage _____



DEPARTMENT: CORENEWBUS TASK: INDCHANGE

Annuities are issued by MetLife Insurance Company of Connecticut (MIC), One Cityplace, Hartford, CT 06103 and distributed by MetLife Investors Distribution Company (MLIDC) (member FINRA), 5 Park Plaza, Suite 1900, Irvine, CA 92614. Securities, including variable products offered through MetLife Securities, Inc. (MSI) (member FINRA/SIPC), 200 Park Avenue, New York, NY 10166. MIC, MLIDC and MSI are affiliates.

Participant Name: _____

Participant's SSN or TIN: _____

457(b) Deferred Compensation Plan
BENEFICIARY DESIGNATION

SECTION 3 – PARTICIPANT CERTIFICATION

I certify that everything I said on this form is true, correct, and complete. I certify, under penalties of perjury, that my Social Security Number or other Taxpayer Identifying Number shown above is correct. I understand that I may be subject to civil and criminal penalties and punishment for any knowingly false statement on this form. If the Plan pays or fails to pay any benefit based on my false statement, I will be liable for the Plan's damages, including (but not limited to) investigation expenses and lawyers' and legal assistants' fees.

Participant's Signature

Date

SECTION 4 – SUBMITTING THIS FORM

Please mail completed, signed form to:

Attn: Enrollment Services
MetLife
PO Box 6717
Somerset, NJ 08875