

Annuities

Nursing care withdrawal request

This form is to be used to exercise the Nursing Care Rider Waiver of Withdrawal Charge. The provision allows for a full or partial withdrawal free of any contract withdrawal charges. The Owner may exercise this withdrawal free of any contract withdrawal charges only if this provision has been approved in his/her state. Please consult your MetLife Account Representative for details on availability. A separate Nursing Care Withdrawal form must be completed for each annuity contract. In addition, a new Nursing Care Withdrawal form is required every time the rider is utilized.

Metropolitan Life Insurance Company

Things to know before you begin

- The Contract Owner or Joint Owner must be confined to a qualifying institution for at least 90 consecutive days or confined for a total of at least 90 days if there is no more than a 6-month break in the confinement and the confinements are for related causes.
- The First confinement must begin on or after the first Contract Anniversary.
- The Withdrawal request and satisfactory proof of confinement must be received by MetLife while the Contract Owner or Joint Owner is confined, or within 90 days immediately following confinement.
- Nursing Home and/or Hospital confinement must be prescribed by a licensed physician and be medically necessary.
- If changes to the Contract Ownership, other than a Spousal Beneficiary Continuation have occurred since the Issue Date, Withdrawal Charges will not be waived.
- The age of the Contract Owner or Joint Owner must be less than the maximum Nursing Home or Hospital Confinement Rider Issue Age at the time of Contract Issue.
- If a Withdrawal Charge has or will be waived for Nursing Home or Hospital Confinement under the terms of the Rider, Purchase Payments can no longer be made under the Contract.

SECTION 1 - Contract information

Contract number

Owner's first name | Middle name | Last name

Street address

City | State | ZIP

Owner's Social Security number or TIN | Primary phone number

Annuitant

Form completed by: *(First, Middle, Last)* | Relationship to Owner

SECTION 2 - Requirements – Documents to be forwarded to MetLife

1. This form, completed and signed by the Contract Owner(s)
2. A letter from each Nursing Home and/or Hospital on their letterhead confirming that the Owner is or was confined and the dates of confinement. The letter must include confirmation that each Nursing Home and/or Hospital is a state licensed facility and include its state license number. (License number not required in WA.)
3. The Medical Questionnaire below must be completed and signed by the attending Physician.

SECTION 3 - Withdrawal request: *(Check one)*

Full withdrawal

- I request a full withdrawal of the accumulated value of my contract.

Florida Residents Only

- Check this box: If your insurance agent recommended (advised) you to surrender your annuity contract and the surrender proceeds will NOT be used to fund or purchase another life insurance policy or annuity contract.*

- The state of Florida requires that we first provide you with important disclosure information.
- We are unable to send your surrender proceeds via EFT or wire. We will promptly send you a check.
- Include your email address or fax number in the space provided below so we can send the important disclosure information to you.

Email address/fax number:

Partial withdrawal

- Please process a withdrawal for the **net amount of:**
I request a partial withdrawal in the amount of: \$ _____

Alternate payment instructions

Choose One (Optional)

Note: A check will be sent to the address on record if Electronic Funds Transfer or Alternate Payee is not selected below. If made payable to a third party, a Medallion Signature Guarantee is required, and the original will need to be mailed in to us.

- 1. Electronic Funds Transfer**

Note: It may take up to 3 business days for the funds to appear in your bank account. It is the Contract Owner's responsibility to inform MetLife of any changes to banking information.

Bank name

Bank address

City

State

ZIP

Bank account number

Bank ABA number

Type of account:

Checking (A copy of a voided check is required.)

Savings (A letter of instruction on bank letterhead, containing EFT information and account registration, is required.)

2. Check

Alternate Payee name (Bank, Brokerage Firm, etc.)

Alternate Payee address	City	State	ZIP
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Account number (if applicable)

SECTION 4 - Medical questionnaire – to be completed by attending physician

Name of Patient

The above named patient has authorized MetLife to obtain medical information in order to evaluate his/her request for a waiver of Withdrawal Charge under his/her Annuity Contract. Please answer the following questions and submit the completed and signed form to the address in the "How to Submit this Form" section below.

1. Is this patient confined in a medical care facility which is providing in-patient care because of a physical limitation which prohibits daily living in a non-institutional setting? Yes No

If yes, please describe the physical limitations or special requirements. (If more space is needed, please attach a separate page.)

2. Did you prescribe the confinement? Yes No If No, who did? _____

3. Provide the name(s) of the facility to which the patient was confined and the confinement dates.

Name of Facility	License number	Address	Confinement began	Confinement ended

Nursing Home(s) and/or Hospital(s) meet the following definition:

1. A Skilled Nursing Facility, Intermediate Care Facility, or Residential Care Facility located in the United States or its territories; licensed according to the laws of the jurisdiction in which it is located; provides continuous 24 hour a day nursing services under the supervision of a RN or LPN; and maintains a daily record of each patient; or
2. A Hospital located in the United States or its territories and licensed by the jurisdiction in which it is located; supervised by a staff of licensed physicians; provides nursing services 24 hours a day under the supervision of a R.N.; operates primarily for the care and treatment of sick and injured persons as inpatients for a charge; and has access to medical and diagnostic facilities.

By my signature, I attest to the fact that this information is correct and that the Patient is not a member of my immediate family.

Name of attending physician (*Please print*)

Physician's state licence number

Signature of physician

Date (*mm/dd/yyyy*)

Daytime phone number

Best time to contact you

Office address

SECTION 5 - Special instructions

SECTION 6 - Federal income tax status and withholding

NOTE: If neither of the below withholding elections is chosen, under current federal income tax law MetLife is required to withhold 10 percent of the taxable portion of annuity distributions for federal income taxes. State income tax may also be withheld, if applicable.

Check one:

I elect to have federal and state, if applicable, income tax withheld from these distributions.

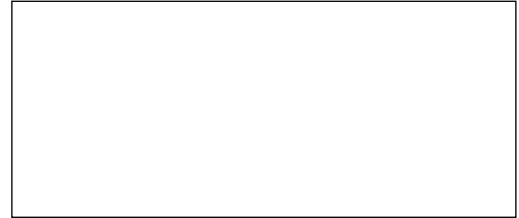
Federal _____ % State _____ % Owner's state of residence _____

I elect NOT to have federal and state, if applicable, income tax withheld from these distributions.

Note: Even if you elect not to have income tax withheld from a distribution, you are liable for payment of income tax on the taxable portion of your withdrawal. You may also be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate. Additionally, a 10 percent federal tax penalty may be assessed against distributions if the Owner is under age 59 ½. You should consult your tax advisor regarding your personal situation.

SECTION 7- Required signature(s)

Payee: MetLife will make the check payable to the Owner(s) at the address on file unless indicated otherwise below. If the Owner(s) choose to make the check payable to a party other than themselves, a Medallion Signature Guarantee will be required.



Medallion Signature Guarantee

Owner signature	Title, if applicable	Date (mm/dd/yyyy)
Joint Owner signature	Title, if applicable	Date (mm/dd/yyyy)

NOTE: If the Contract Owner is unable to sign, a Power of Attorney or Attorney in Fact document or court-certified Letters of Guardianship/Conservatorship must accompany this request.

SECTION 8 - How to submit this form

Return this form to MetLife Annuities by:

Mail:

P.O. Box 10342
Des Moines, IA 50306-0342

For Express mail only:

4700 Westown Parkway, Ste. 200
West Des Moines, IA 50266

Fax:

877-547-9669