

Address change request form

Metropolitan Life Insurance Company

Things to know before you begin

- Use this form for changing the mailing address of correspondence

SECTION 1: Claimant's information *(Please print name of insured and address below)*

Regarding the MetLife Long-Term Care coverage for:

First name	Middle name	Last name
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Group or Policy Number	Date of birth <i>(mm/dd/yyyy)</i>
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I would like to request to change the mailing address for all correspondence for the claimant listed above to the following new address:

Address	City	State	ZIP
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Additionally, the home phone number should be listed as _____

Sign Here	Signature of Claimant	Date <i>(mm/dd/yyyy)</i>
	_____	_____
Sign Here	Signature of POA or Executor <i>(if applicable)</i>	Date <i>(mm/dd/yyyy)</i>
	_____	_____

SECTION 2: How to submit this form

Mail:
 MetLife
 Long Term Care Claims
 P.O. Box 14407
 Lexington, KY 40512-9800

Fax:
 866-722-1180

Email:
 longtermcareclaims@metlife.com