

legal & tax trends

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APRIL 2006

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MODIFIED ENDOWMENT CONTRACTS

Inside this issue

- **Introduction**
- **Definition of Life Insurance**
- **Modified Endowment Contracts**
- **Conclusion**



A Note to our Readers

In this issue of **Legal & Tax Trends** we focus on life insurance policies that are classified as Modified Endowment Contracts (MECs). A MEC refers to certain cash value life insurance policies that have less attractive income tax benefits for cash value withdrawals and loans. We discuss how a life insurance policy can become a MEC and the consequences that result from such a classification. We also discuss how a life insurance policy can be “cured” of its MEC status, as provided in Revenue Procedure 2001-42.

Introduction

Modified endowment contracts have been part of the insurance landscape for close to 20 years. They were created by the Technical and Miscellaneous Revenue Act of 1988 (TAMRA) which was signed into law by President Reagan on November 10, 1988. TAMRA added new section 7702A to the Internal Revenue Code, which sets forth the rules that determine when a life insurance policy will be treated as a modified endowment contract.¹

Before TAMRA was signed into law, single premium life insurance policies were being touted as the last great tax shelter. The single premium policy was being sold as an investment since the owner would often deposit large sums of money into the policy with the intent of later accessing basis in a tax favored manner. The investment benefits, and not the insurance coverage, were the primary reason many individuals had for purchasing the single premium life policy.

¹ P.L. 100-647, §5012(1).

The purpose of the new Code section was to discourage the use of investment-oriented life insurance policies as a form of a tax shelter. In fact, in many respects the MEC legislation represented the culmination of Congressional efforts throughout the 1980s to restrict the tax benefits of life and annuity contracts. The Tax Equity and Fiscal Responsibility Act of 1982, for example, fundamentally altered the taxation of annuity contracts by treating amounts withdrawn from an annuity as a withdrawal of income first, rather than basis, and by treating loans and assignments as taxable distributions. It also added rules that applied to flexible premium life insurance contracts.

The Deficit Reduction Act of 1984 (DEFRA) further tightened the rules governing annuities, and in addition, added a new Code section that for the first time set forth a definition of life insurance for federal income tax purposes that applied to all contracts and not just flexible premium contracts. New section 7702 provided that a policy of life insurance would only be treated as a “life insurance contract” and thereby enjoy the benefits of tax-deferred cash value accumulation and tax-free death benefits if it met its definitional requirements.²

It was the development of flexible premium adjustable life (universal life) policies in the late 1970s, and the marketing of these products primarily for their investment features rather than death protection, that compelled Congress to take action, first enacting section 101(f) and later section 7702. In an effort to discourage the use of heavily investment-oriented policies, new section 7702 required policies to meet one of two alternative tests aimed at establishing a mandated relationship between a policy’s permissible funding level and its death benefit. Nevertheless, single premium life insurance policies, despite their investment orientation, were able to satisfy these tests.

When the Tax Reform Act of 1986 severely curtailed the benefits of tax shelters, single premium life insurance policies became particularly attractive investment vehicles. The popularity of these products was not lost on Congress and in 1988 resulted in the creation of the modified endowment contract as a new form of life insurance policy governed by new section 7702A. If a policy is treated as a modified endowment contract, its cash value will continue to accumulate on a tax-deferred basis, and death proceeds will continue to be tax-free under section 101(a). Lifetime distributions from the policy will be taxed similar to distributions from an annuity contract (gain distributed first and then basis) rather than an insurance policy that is not a MEC. This means that a loan, pledge or an assignment of a MEC will be considered a deemed distribution from the policy. Additionally, an additional 10% tax will be imposed on the taxable portion of a distribution if the owner is under 59 ½ subject to certain exceptions for disability and substantially equal periodic payments.

² P.L.98-369§221(a)

It is widely assumed that if a policy does not become a MEC within the first seven policy years it will never become a MEC. Unfortunately this is not true.

Many policies can become modified endowments well after the first seven policy years. This would obviously be unwelcome news to policyholders who have been accumulating cash values with the intention of drawing upon those values at retirement through nontaxable withdrawals of basis and policy loans. The fact that these withdrawals and loans would instead be taxable to the extent of the gain could frustrate a client's plan. Given the complexity of the modified endowment contract rules, it is not surprising that in some cases policies have inadvertently become MECs.

This article will examine the rules surrounding modified endowment contracts with a focus on the circumstances under which a policy can become a MEC. The article will also review the different tax rules pertaining to distributions from a MEC and what a policyholder can do to avoid MEC status. It will also address what an insurer can do to correct an inadvertent MEC. In addition, there will also be a discussion of the situations where a MEC may present some unique problems that will not be encountered with a non-MEC policy.

Definition of Life Insurance

In order to fully understand how the MEC rules are applied to policies, it is useful to first review the definition of life insurance under section 7702 since the MEC rules under section 7702A draw on many of the computational principles set out in section 7702. As noted above, section 7702 defines a life insurance contract as a policy which is a life insurance contract under state law and which meets one of two alternative tests: (1) the cash value accumulation test; or (2) the guideline premium/cash value corridor test. The former test is generally applied to traditional whole life and ordinary variable life policies whereas the latter is generally applied to flexible premium (universal and universal variable) life insurance contracts.

- *Cash Value Accumulation Test*

The cash value accumulation test (CVAT) provides that a policy will be treated as a life insurance contract if, based on its terms, the cash value of the contract, without regard to surrender charges, policy loans or reasonable termination dividends, can at no time exceed the net single premium necessary to provide the policy's future benefits, that is, generally to pay up the policy.³

For purposes of the cash value accumulation test, the net single premium is generally determined by using: (1) the age of the insured; (2) the death benefit

³ IRC §7702(b).

provided under the contract; (3) reasonable mortality charges; and (4) an assumed interest rate equal to the greater of 4 percent or the amount guaranteed in the contract.⁴ The net single premium so derived may not, however, actually be sufficient to pay up the policy because it is the *net* single premium, meaning expenses are not taken into consideration. To this extent the net single premium is an artificial construct, but it is intended to provide a general standard with which to measure the investment-oriented nature of the policy.

- *Guideline Premium/Cash Value Corridor Test*

The guideline premium/cash value corridor test provides that a policy will be treated as a life insurance contract if, in fact: (1) the sum of the premiums paid at any time do not exceed the greater of the net single premium or the sum of the net level premiums at such time (the “guideline premium” portion of the test); and (2) the death benefit is at least equal to a specified percentage, which varies with the age of the insured and is set forth in a table under section 7702, of the policy’s cash value (the “cash value corridor” portion of the test).⁵

In contrast to the cash value accumulation test, the guideline premium/cash value corridor test is based on gross premiums actually paid, so expenses are taken into consideration in determining the policy’s guideline single premium and guideline level premiums. The expenses must, however, be those the insurer reasonably expects will actually be paid.⁶ Similar to the net single premium, the guideline single premium is the amount which would have to be paid to provide the future benefits under the policy. Here, however, the interest rate assumed is the greater of 6 percent or the rate or rates guaranteed on issuance of the contract for the guideline single premium and the greater of 4 percent or the rate or rates guaranteed on issuance of the contract for the guideline level premiums.⁷

If a policy fails to meet either of these tests at any time, it will no longer be treated as a life insurance contract and will no longer provide tax-deferred cash value build-up nor, generally, tax-free death benefits. Moreover, all undistributed income on the policy from all prior years will be deemed distributed and subject to current taxation. Insurers monitor their policies for compliance with section 7702 and can take appropriate action if a policy is in danger of failing. In such an

⁴ IRC §7702(b)(2).

⁵ IRC §7702(c).

⁶ IRC §7702(c)(3)(B).

⁷ Id., IRC §7702(c)(4). The following computational rules apply in determining both the net single premium and the guideline single and level premiums: (1) with a limited exception, the original death benefit is deemed to be provided for the life of the contract; (2) the maturity date must be deemed to be no earlier than the insured’s age 95 birthday and no later than age 100; (3) the death benefit must be deemed to be provided until maturity; and (4) the endowment benefit or the cash surrender value upon maturity cannot exceed the lowest death benefit provided under the contract. See also IRC §7702(e).

event, the insurer can refuse to accept premium or distribute amounts from the policy that would otherwise cause the policy to fail the definitional test.

Modified Endowment Contracts

- *The 7-Pay Test*

A modified endowment contract is a life insurance contract (as defined under section 7702) which is entered into on or after June 21, 1988 and which fails to meet the “7-pay” test set forth in section 7702A(b), or which is received in exchange for a modified endowment contract.⁸ The 7-pay test will be failed if, at any time in the policy’s first seven years, the total amount paid into the policy exceeds the sum of the net level premiums which would have been paid as of such time if the policy provided for paid-up benefits after the payment of seven level annual premiums.⁹ The statutory design underlying the 7-pay test is clear: if a policy can reach paid-up status with the payment of *fewer* than seven level annual premiums, it is too investment-oriented and lifetime distributions from the policy will receive the same income tax treatment accorded distributions from annuity contracts.

The 7-pay test is applied to premiums paid on a cumulative basis. So long as the cumulative amount paid into the contract at any point is less than the sum of the 7-pay premiums to date, it is possible for a premium in excess of the annual limit to be paid in any single year without violating the rule. For example, assume an individual purchases a flexible premium policy that has a \$100,000 death benefit and a 7-pay premium of \$5,000. In year 1 the insured pays a premium of \$3,000, in year 2 he pays a premium of \$5,000, and in year 3 he pays \$7,000 into the policy. Although \$7,000 is clearly in excess of the 7-pay limit, the payment does not violate the 7-pay test because payments in years 1 and 2 totaled only \$8,000. Since the 7-pay test would have allowed \$10,000 (2 x \$5,000) to have been paid in years 1 and 2, the \$2,000 shortfall originating in year 1 can be made up in year 3 without violating the test.

The 7-pay premium is determined at policy issue by applying the same computational rules as are used to compute the net single premium under the cash value accumulation test of section 7702.¹⁰ Again, since it is the *net* single

⁸ IRC §7702A(a).

⁹ IRC §7702A(b).

¹⁰ IRC §7702A(c).

premium which is calculated, expenses are not taken into consideration, potentially resulting in a premium that would actually be insufficient to pay up the policy in seven years.

The method of calculation is the same for policies meeting both the cash value accumulation test and the guideline premium/cash value corridor test, despite the fact that the guideline premium/cash value corridor test allows expenses to be taken into consideration.¹¹

- *Material Changes*

A policy that is not a modified endowment contract when issued may become a MEC due to the payment of premiums in excess of the cumulative 7-pay limit. A policy may also become a MEC if it undergoes a “material change.”¹² A material change is defined to include *any* increase in the future benefits under the policy (subject to certain exceptions).¹³ The legislative history to section 7702A includes a policy exchange and a conversion from term to permanent insurance as examples of material changes.¹⁴ Thus, a material change would include an increase in the death benefit under a policy, or, generally, the section 1035 exchange of one policy for another. If a policy undergoes a material change, a new 7-pay premium must be determined for the policy and a new 7-pay period will begin to run. The new 7-pay premium is calculated using the age of the insured and the policy’s death benefit at the time of the material change.

To prevent the policy from being over-funded, the new 7-pay premium for each of the seven years following the change must be reduced to account for the cash value of the policy existing as of the date of the material change. If a policy with a significant amount of cash value undergoes a material change, the adjustment which must be made to the new 7-pay premium to account for that cash value may result in a very small or perhaps a zero 7-pay limit. Under these circumstances little or no additional premiums could be paid into the materially changed policy without causing it to become a MEC.

- *Section 1035 Exchanges*

¹¹ Expenses can only be taken into account in two specific situations. Under the first exception, the annual 7-pay limit for policies with an initial face amount of \$10,000 or less, and which require at least seven non-decreasing annual premiums, may be increased by \$75 to account for the fact that policies with small face amounts often have large expense loads in their premiums. To preclude the use of multiple \$75 expense allowances, however, all policies previously issued to the same insured by the same insurance company or its affiliates must be aggregated in determining the initial death benefit. Under the second exception to the no-expense allowance rule, the Treasury Department may issue regulations that would allow taking into account expenses attributable to the collection of premiums paid more frequently than annually. See also IRC §§7702A(c)(4) and (c)(5).

¹² IRC §7702A(c)(3)(A).

¹³ IRC §7702A(c)(3)(B).

¹⁴ P.L. 100-647, Conf. Rpt. at 105.

As noted above, the exchange of a policy under section 1035 is generally a material change requiring a re-test of the policy. Yet, although the exchange involves the issuance of a new insurance policy, the cash value of the existing contract is not treated as a premium contribution and therefore, does not cause the policy to become a MEC, even if the cash value is well in excess of the 7-pay limit. However, the cash value must be taken into account in determining the 7-pay premium for the new policy that will result in an adjusted 7-pay premium that may limit or preclude the payment of any additional premiums into the new policy.

- *Reduction in Benefits*

If there is a reduction in the benefits provided under the policy within the first seven policy years (or within the seven-year period following a material change), the policy will have to be re-tested as if it were originally issued with the lower death benefit.¹⁵ The re-test will result in a lower 7-pay premium, which, when applied to the amounts actually paid into the policy, may cause the policy to be over funded and therefore to become a MEC. The benefit reduction re-test requirement is designed to prevent manipulation of the MEC rules. In the absence of this requirement, a policy could be issued with a death benefit that would initially meet the 7-pay test, but then could be reduced, thereby requiring no additional or substantially reduced premium payments. However, the re-test would also affect a policy that is converted to reduced paid-up insurance during a 7-pay period. It can also affect policies that are exchanged during a 7-pay period.

With one notable exception, a reduction in a policy's death benefit after the 7-pay period has elapsed will not trigger a re-test of the policy. Under the exception, if the death benefit under a *last-to-die* policy is reduced *at any time* below the lowest level of death benefit provided in the first seven contract years, the policy must be re-tested and a new 7-pay limit determined based on the reduced death benefit amount.¹⁶ Thus, a last-to-die policy in force for many years could become a modified endowment contract as a result of a death benefit reduction. As a practical matter, the impact of this rule may be limited given that most last-to-die policies are acquired for estate liquidity purposes rather than lifetime benefits, and are typically owned by trustees who neither borrow nor take withdrawals from the policy. Nevertheless, the potential application of this rule cannot be overlooked when an estate plan is being designed.

- *Material Changes After Seven Policy Years*

Although a reduction in benefits after the 7-pay period will generally not trigger a re-test of a policy, a material change at any time in the life of a policy will require a re-test. A material change includes a material change in the terms and benefits

¹⁵ IRC §7702A(c)(2).

¹⁶ IRC §7702A(c)(6).

of the contract that were not reflected in any previous 7-pay determination and, generally *any* increase in the death benefit provided under a policy, no matter how nominal. Application of this rule suggests, for example, that whenever the death benefit under a variable policy increases due to the favorable investment experience of the sub-accounts, a material change would occur and a re-test would be necessary. There are, however, two exceptions to this rule that would prevent this type of benefit increase (and others) from constituting a material change. Under the exceptions, a benefit increase is not considered a material change if it is attributable to: (1) certain cost-of living adjustments; and (2) the payment of “necessary” premiums. The former exception provides that to the extent allowed in Treasury regulations, future benefit increases will not be treated as a material change if they are based on an established, broad-based index (such as the Consumer Price Index) specified in the policy, and if the additional premiums required to fund such increases are paid ratably over the policy’s remaining life. As of the date hereof, no such Treasury regulations have been issued, meaning that no exception for cost-of-living increases are currently in effect.¹⁷ The second exception, for increases attributable to the payment of “necessary” premiums, is a far more complex concept to apply and understand.

- *The Necessary Premium Exception*

The “necessary premium” exception provides that future increases in benefits under a policy will not be treated as a material change and therefore will not trigger a re-test of the policy so long as the increase is attributable to: (1) the payment of premiums necessary to fund the lowest death benefit payable under the policy during the first seven contract years; or (2) the crediting of interest or other earnings, including policyholder dividends, on those necessary premiums.¹⁸ The rationale underlying the exception is, in part, that the material change rules are intended to apply to increases in benefits resulting from a change initiated by the policyholder rather than benefit increases which occur automatically under the policy, such as the crediting of earnings or the investment of dividends in paid-up additions. However, in order for a premium to be deemed a necessary premium, the technical requirements must be met. *Please see Appendix A for additional information on the technical requirements.*

- *Payment of an Unnecessary Premium*

If an unnecessary premium is paid and a benefit increase follows, the materially-changed policy will have to be re-tested to determine its status as a modified endowment contract. For example, under a traditional ordinary life policy, premiums used to purchase paid up additional insurance can constitute unnecessary premiums which, if paid year after year, may eventually result in a material change. Under a variable ordinary life policy, an unscheduled premium,

¹⁷ IRC §7702A(c)(3)(B)(ii).

¹⁸ IRC §7702A(c)(3)(B)(i).

or dump-in, can similarly constitute an unnecessary premium that may eventually result in a material change. Upon a re-test of a traditional ordinary life policy, the 7-pay test may or may not be failed.

- *Failing the 7-Pay Test*

If a contract fails the 7-pay test, distributions (including policy loans and assignments or pledges) will be treated as income to the extent of the gain in the policy and may be subject to a 10 percent penalty tax if the policyholder is under age 59½.¹⁹ The penalty would apparently always apply to a policy owned by a non-natural person, such as a corporation or a trust. It will not apply to distributions attributable to the policyholder becoming disabled nor to amounts received as part of a series of substantially equal periodic payments for the life expectancy of the policyholder or the joint life expectancy of the policyholder and his or her beneficiary.²⁰

If a policy becomes a modified endowment contract there is a look-back provision which would treat amounts distributed within two years of the failure as having been received in anticipation of the failure.²¹ Such amounts would be includible in income for the year in which received. However, the look-back rule will not apply to any policy that is returned to non-MEC status through appropriate action by the policyholder.

A policy that has become a MEC can be returned to non-MEC status if the payment which caused the policy to violate the 7-pay test is returned to the policyholder, with interest, within 60 days after the end of the policy year in which the payment was made. Insurance companies generally need policyholder permission to return premium. A letter is generally sent to the policyholder offering to make the refund. A failure of the policyholder to timely authorize a refund will result in MEC status for the policy. However, a timely request for a refund will prevent MEC status.

There are instances where policies become inadvertent MECs due to systems limitations or administrative error. To address this concern, the IRS issued Revenue Procedure 2001-42. Please see Appendix B for a detailed discussion of this MEC correction procedure.

The correction procedure set out in Revenue Procedure 2001-42 (superseding Rev. Proc. 99-27) is welcome news for many insurers who have issued

¹⁹ IRC §72(e)(10), §72(v)(1).

²⁰ IRC §72(v)(2).

²¹ IRC §7702A(d).

insurance policies that have inadvertently become modified endowment contracts. It provides a methodology by which these contracts can be cured of their MEC status with obvious benefits for both policyholders and insurers. The correction procedure reinforces the fact that the modified endowment contract rules remain extremely complex and that compliance with them has evaded even the most diligent of insurers. The good news is that improved compliance systems and procedures, in conjunction with the opportunity to correct failed policies, will allow most insurers to bring most of its policies into compliance.

Conclusion

It is important to continually monitor changes to a client's policy to avoid re-testing and the possible creation of a MEC. If a client purchases a MEC, or makes changes to a policy that results in the creation of a MEC, it is important that the client understand the consequences of owning a modified endowment contract. Finally, remember that there are instances, such as with a last to die policy, where owning a MEC may not adversely impact the planning process. A MEC is not necessarily a problem so long as the client does not require access to the policy values and the policy meets the planning needs of the client.

APPENDIX A

The Necessary Premium Exception – Technical Requirements

A necessary premium, as noted above, is one that will provide a level amount of death benefit equal to the lowest guaranteed death benefit provided in the first seven contract years (or the seven years following a material change). The calculation of necessary premiums, unlike the calculation of the 7-pay premium, is performed differently for policies satisfying the cash value accumulation test than it is for policies satisfying the guideline premium/cash value corridor test. In the case of a policy satisfying the cash value accumulation test, a premium is deemed necessary to the extent the premium paid, net of expenses, is not greater than the excess, if any, of: (1) the “attained age net single premium” for the policy immediately before the premium payment, over (2) the policy’s “deemed cash surrender value” or actual cash value, if less.¹ Stated differently, a premium will be treated as a necessary premium to the extent it is less than or equal to the amount that would be required to pay up the lowest death benefit during the most recent 7-pay period. The “attained age net single premium” is calculated using the same computational methods used to calculate a policy’s net single premium for purposes of section 7702. It is based on the insured’s attained age and assumes the lowest death benefit during the most recent 7-pay period is provided for life.

Cash Value Accumulation Test Policies—Deemed Cash Surrender Value

For policies satisfying the cash value accumulation test, the determination of unnecessary premiums requires the determination of a policy’s “deemed cash surrender value.” This value must be compared to the net single premium to determine how much room there is for additional, “necessary” premium. The deemed cash surrender value is a hypothetical cash value determined by crediting the amounts actually paid into the contract with interest at the greater of 4 percent or the amount guaranteed in the contract and reduced by the expense and mortality charges taken into account for prior periods.² The result is a cash value amount that could be far less than the actual cash value of the contract given that it is based on the interest rate guaranteed in the contract, which may be well below the Company’s actual experience.

¹ P.L. 100-647, H. Rpt at 104-105

² P.L. 100-647, H. Rpt. at 481

Guideline Premium/Cash Corridor Test Policies

For policies satisfying the guideline premium/cash value corridor test a premium is generally necessary to the extent it does not exceed the excess, if any, of (1) the greater of the guideline single premium or the sum of the guideline level premiums to date for the policy, over (2) the sum of the premiums previously paid for the policy.³ The former, of course, is the limit on amounts that can be contributed to a policy and still meet the definition of a life insurance contract. Thus, a necessary premium is an amount that falls within the guideline premium limit. However, because necessary premium relates to the lowest death benefit in a 7-pay test period. It may or may not be the same as the actual guideline premium limit under section 7702.

APPENDIX B

The MEC Correction Procedure—Revenue Procedure 2001-42

The Internal Revenue Service is well aware that due to the complexity of section 7702A and the attendant difficulty of complying with its terms, that many insurers have issued contracts which have inadvertently become modified endowment contracts. Insurers have worked with the Service for several years on a correction procedure that would allow inadvertent MECs to be returned to non-MEC status.

The Service released Revenue Procedure 99-27, and Revenue Procedure 2001-42 which superseded Rev. Proc. 99-27, to provide procedures by which an insurer may remedy “an inadvertent non-egregious failure” to comply with the modified endowment contract rules under section 7702A of the Internal Revenue Code. This will allow insurers to correct most, but not all, of its inadvertent MECs, but at a price. The procedure requires an insurer to determine the amount of the excess premium paid into the contract, i.e., the “overage” for each of the seven years of the 7-pay period. Earnings on these “overages” are then calculated at varying annual rates, which differ for traditional and variable policies. A tax on these earnings, known as “toll charge,” must be paid to the IRS. In addition, if any distributions were made from the policy during the 7-pay period, an income tax on the distributions must be calculated, along with interest using the rate applicable to underpayments of tax, and finally, an additional 10 percent penalty

³ P.L. 100-647, Conf. Rpt. At 105

tax, if applicable. The cumulative amount must be remitted to the Internal Revenue Service.

“Incurable” Policies

Since the procedure only applies to inadvertent and non-egregious failures, it cannot be used to cure policies that were designed to be MECs, for example, single premium policies and those requiring the payment of fewer than seven annual payments.

The Service may exclude a contract from the correction mechanism provided under this revenue procedure if the contract's status as a MEC resulted from a failure to comply with the requirements of section 7702A that:

- (1) Are attributable to one or more defective interpretations or positions that the Service determines to be a significant feature of a program to sell investment-oriented contracts, or;
- (2) arises where the controlling statutory provision, as supplemented by any legislative history or guidance published by the Service, is clear on its face and the Service determines that failure to follow the provision results in a significant increase in the investment orientation of a contract.

Seeking Relief

Revenue Procedure 2001-42 outlines the procedures an insurer must follow in order to correct the “inadvertent and non-egregious MECs” and enter into a closing agreement with the Service. While it is cheaper to correct all affected policies at the same time, there may be instances where an insurer may have to resort to multiple filings. The insurer must remit with the filing a toll charge which includes taxes due on distributions, deficiency interest thereon, tax on overage earnings and any applicable penalty tax. These payments are not deductible by the insurer nor do they have any effect on the policyholder's basis in the contract.

Finally, to actually restore a policy to non-MEC status, the insurer must then take corrective action by either increasing the death benefit under the policy or by returning any excess premiums with interest to the policyholder. The interest, would of course, be taxable to the policyholder.

Legal & Tax Trends is provided to you by a coordinated effort between the advanced markets attorneys in both the Advanced Markets Organization and the Law Department. The following individuals contribute to this publication: From the Advanced Markets Organization; Thomas Barrett, Kenneth Cymbal, John Donlon, Lori Epstein, Jeffrey Hollander and Jeffrey Jenei, Barry Rabinovich; From the law department, Stephen Chiumenti, and Stacy Wolfe.

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