

**LONG TERM DISABILITY
CLAIM FORM
EMPLOYEE STATEMENT**



Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-800-230-9531

Instructions for completing the claim form:

1. Complete all applicable areas of the claim form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the claim form.
4. Fax this form to expedite your claim – retain original for your records.
5. *Contact MetLife at 888-444-1433 for any questions you have on completing this form.

Section 1: Personal Information					
Name (Last, First, MI) – MUST ANSWER		Employer – MUST ANSWER		Group Report #	Social Security # MUST ANSWER
Address		City	State	Zip Code	Date of Birth (MM/DD/YY)
					Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone #	Work Phone #	Occupation	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		Tax Exemptions
Dependent Information:					
	Name	Date of Birth		SS#	
Spouse	_____	_____		_____	
Children	_____	_____		_____	
	_____	_____		_____	
	_____	_____		_____	
Section 2: Claim Information					
Is your disability due to <input type="checkbox"/> Injury/Accident? <input type="checkbox"/> Illness?			If due to injury/accident, give date, time and details.		
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No			(When, Where, How)		
Date of first treatment for this condition	Date Last Worked MUST ANSWER	Date Disability Began	Height	Weight	
Name, address, phone number of your primary attending physician.					
Name of physicians/providers who have treated you within the past 2 years.					
<u>Name of Physician/Provider</u>	<u>Phone Number</u>	<u>Dates of Treatment</u>		<u>Reason for Visit</u>	
_____	_____	From	To	_____	
_____	_____	From	To	_____	
_____	_____	From	To	_____	
Has the patient been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give dates from _____ to _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient					
Name and address of hospital					
Circle Highest Education Level Completed.			Degrees, Certificates, License/Skills or training obtained		
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18					
Please describe what prevents you from performing the duties of your job.					
Have you applied for or are you receiving income from any other sources? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information.					
	Applied for	Receiving	\$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
No Fault (Income Replacement)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Retirement/Pension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Permanent Total Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other (Please Identify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Name: (Last, First, Middle Initial)

Social Security #

Report #

Claim #

Agreement To Reimburse Overpayment of Long Term Disability Benefits

I, _____ acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company (MetLife) is authorized to reduce the benefits otherwise payable to me by certain amounts paid or payable to me under disability or retirement provisions of the Social Security Act (including any payments for my eligible dependents), under a Worker's Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that, if my disability claim is or has been approved, MetLife is willing to make advance monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. However, I also understand and accept that MetLife will make these payments, only if I make certain statements which I represent and warrant to be true and only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.
2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.
3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.
4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.
5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement.
6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.
7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues an advance, it is relying on my statements and agreements herein. My acceptance of an advance, along with my signature below, is my acceptance of terms of this Agreement.

Witness Signature

Date

Claimant's Signature

Date



Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-800-230-9531

HIPAA: This Authorization has been carefully and specifically drafted to permit disclosure of health information consistent with the privacy rules adopted and subsequently amended by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Instructions for completing the form:

1. Complete all applicable areas of the form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign this form.
4. Fax or return this form as soon as possible to expedite processing of your claim – retain original for your records.

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's disability plan.

Name of Employee (Please Print)

Social Security Number

Claim Number: _____

Authorization to Disclose Information About Me

For purposes of determining my eligibility for disability benefits, the administration of my employer's disability benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its disability benefit plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and disability claim.
2. **I permit:** MetLife to disclose to my employer in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. **Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.**

I understand that I may revoke this authorization at anytime by writing to MetLife Disability at P.O. Box 14590, Lexington, KY 40511-4590, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

Signature of Employee

Date

Disability Claim Employee Statement (Continued)

Fraud Warning:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim with materially false information or conceals for the purpose of misleading, information concerning any fact material there to may be guilty of committing a fraudulent insurance act. Please see below for special notice required by state law.

Alaska – A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona – For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of loss is subject to criminal and civil penalties.

Arkansas, Louisiana, West Virginia – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California – For your protection California law requires the following to appear of this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds, shall be reported to the Colorado divisions of insurance within the department of regulatory agencies to the extent required by applicable law.

Delaware – Any person who knowingly and with the intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia – **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida – Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii – For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Idaho – Any person who knowingly and with the intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Indiana – A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky – Any person who knowingly and with the intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material there to commits a fraudulent insurance act, which is a crime.

Maine – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Minnesota – A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire – A person who with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Disability Claim Employee Statement (Continued)

Fraud Warning (*continued*):

New Jersey – Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

New Mexico – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio – A person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Oklahoma – **WARNING:** Any person who knowingly and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Oregon – A person who knowingly and with intent to defraud an insurance company, files a claim containing false, incomplete or misleading information material to such claim, may be guilty of insurance fraud.

Pennsylvania – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico – Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousands dollars (\$5,000), not to exceed ten thousands dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee, Virginia, Washington – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas – Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Name of Employee (Please Print): _____ Social Security Number: _____

Signature of Employee: _____ Date: _____