MetLife

Long Term Disability Claim Form
Employee Statement

Metropolitan Life Insurance Company

254410 ACCG

Instructions for Completing the Claim Form:

- Complete all applicable areas of the claim form.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/ Claimant's behalf.
- Sign the claim form.
- Fax this form to expedite your claim – retain original for your records.
- *Contact MetLife at 888-262-6842 for any questions you have on completing this form.

SECTION 1: Personal Information

First Name *(Must answer)*	Middle Initial	Last Name

Employer *(Must answer)*	ID number *(If applicable)*

Address	City	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Social Security Number *(Must answer)*

We require a street address for our records if a P.O. Box is your mailing address

Home Phone Number	Mobile Phone *(Optional)*	Occupation

Marital Status ☐ Married ☐ Single ☐ Other	Tax Exemptions

Dependent Information

Spouse

First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Social Security Number

Children

First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Social Security Number

First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Social Security Number

First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Social Security Number

SECTION 2: Claim Information

Is your disability due to ☐ Injury/Accident? ☐ Illness?

If due to injury/accident, give date, time and details. *(When, Where, How)* _____

Is this condition work related? ☐ Yes ☐ No

Date of First Treatment for This Condition *(mm/dd/yyyy)* _____

Date Last Worked *(Must answer) (mm/dd/yyyy)*	Date Disability Began *(mm/dd/yyyy)*

Primary Attending Physician

First Name	Last Name

Address	City	State	ZIP Code

Phone Number

_____

Have you been hospitalized?	If Yes, give dates From To
☐ Yes ☐ No	☐ Inpatient ☐ Outpatient

Name of Hospital

_____

Address of Hospital	City	State	ZIP Code

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? ☐ Yes ☐ No

If yes, provide the following information.

	Applied For	Receiving	$ Amount	Frequency	From Date *(mm/dd/yyyy)*	To Date *(mm/dd/yyyy)*
Salary Continuance/Sick Leave	☐	☐				
Short Term Disability	☐	☐				
Worker's Compensation	☐	☐				
Other *(Please identify)*	☐	☐				

First Name	Middle Initial	Last Name

Social Security Number	Claim Number

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 Metropolitan Life Insurance Company 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.

Sign Here	Signature of Claimant	Date *(mm/dd/yyyy)*

MetLife

Authorization to Disclose Information About Me

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Section 2 requires your signature.
- Return this form as soon as possible to expedite processing of your claim as described in How to submit section at the end of the form and keep a copy for your records.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf and include the claim number at the top of each page.

Your refusal to complete and sign this form may affect your eligibility for benefits.

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).

NOTE TO ALL HEALTH CARE PROVIDERS:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 1: Claimant Information

First Name	Middle Name	Last Name
Date of Birth *(mm/dd/yyyy)*	Claim Number	ID Number *(If applicable)*

SECTION 2: Authorization & Signature

For purposes of determining my eligibility for disability benefits or request for reasonable accommodation under the Americans with Disabilities Act (ADA), the administration of my disability benefit plan *(which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits)*, and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any Workers' Compensation, employee assistance or disease management program, 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/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to Metropolitan Life Insurance Company *("MetLife")*, 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 or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, Workers' Compensation, employee assistance, or disease management programs, 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 any time by writing to MetLife Disability at P.O. Box 14590, Lexington KY 40512-4590, 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.

Sign Here	Signature of Claimant	Date *(mm/dd/yyyy)*

Fraud Warnings

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and 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.

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 a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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 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 regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Delaware: Any person who knowingly, and with 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.

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.

Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with 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.

Kentucky: Any person who knowingly and with 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 thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and 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 may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

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

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Pennsylvania and All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto 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 files, assists or abets 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 thousand dollars ($5,000), not to exceed ten thousand 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.

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.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

How to Submit This Form

Mail:
MetLife Disability
P.O. Box 14590
Lexington, KY 40512-4590

Fax:
1-800-230-9531