MetLife

Information needed from you and your physician

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Metropolitan Life Insurance Company

Instructions:

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Submitting an incomplete form may delay processing your claim.
- Please make sure to write your name and claim number at the top of pages 2 to 4. If the pages get separated, this will help to ensure timely processing.
- Some physicians may charge for completion of this form. Any such charge would be your responsibility.
- If you live or work in 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.

Section 1 can be completed by either you or your physician. Section 2 **MUST** be completed by your physician.

To be completed by the person submitting the claim, or by the physician if received directly.

SECTION 1 - About you

Employee name

Employee birth date *(mm/dd/yyyy)*	Employer name	Occupation

Physician - First name	Middle name	Last name

Physician phone number	Claim number

Authorize your physician to share your medical information with us
I authorize my physician to release any information collected in the course of examining or treating me as a patient.

Employee signature	Date signed *(mm/dd/yyyy)*

REQUIRED information in case pages get separated:

Employee name	Claim number

To be completed by the physician providing treatment for the disability condition.

SECTION 2 - Information about your patient's health

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- **After you complete this form, you can fax it along with office notes and results from any diagnostic testing related to your patient's condition (e.g., x-ray, lab tests, EKG or MRI) to 800-230-9531.**

History of your patient's condition

First date of treatment for this condition *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

What is the cause of your patient's symptoms? (*Check one.*)
☐ Injury ☐ Illness ☐ Pregnancy - Type of birth: *(Check one.)*
☐ Caesarean ☐ Natural birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)*

_____

List any other physicians or specialists you referred your patient to:

First name	Middle name	Last name	Specialty	Phone

Is your patient's condition work-related? ☐ Yes ☐ No
Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)*_____ ☐ No
Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)*_____ ☐ No

Facility name	Street address

City	State	ZIP code

About the diagnosis and treatment of your patient

Primary diagnosis code	Description

Secondary diagnosis code	Description

List the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you fax this form to us.)*

REQUIRED information in case pages get separated:

Employee name	Claim number

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT–4 procedure code	Description	Date *(mm/dd/yyyy)*

List any medications prescribed.

Medication name	Dosage

About your patient's restrictions and limitations

Your patient's dominant hand: *(Check one.)* ☐ Right ☐ Left

How many hours in a workday can your patient:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Sit		☐	☐		
Stand		☐	☐		
Walk		☐	☐		
Climb		☐	☐		
Twist/Bend/Stoop		☐	☐		
Reach above shoulder level		☐	☐		
Reach front and side at desk level		☐	☐		
Perform fine finger movements		☐	☐		
Perform eye/hand movements		☐	☐		

How many hours in a workday can your patient lift or carry:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

How many hours in a workday can your patient push or pull:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

Can your patient operate a motor vehicle? ☐ Yes ☐ No

Is your patient at maximum medical improvement? ☐ Yes ☐ No

REQUIRED information in case pages get separated:

Employee name | Claim number

Please make any additional notes.

About your patient's prognosis

Have you advised your patient about when they can return to work?

☐ Yes *(Check all that apply.)*

☐ To regular occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ To any other occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain.)*

List any restrictions to work or activity. *(Please be as specific as possible.)*

If we need more information, who's the best person at your office to contact?

SECTION 3 - Physician's signature and information

Signature		Date signed *(mm/dd/yyyy)*	
First name	Middle name	Last name	
Street address		Degree or specialty	
City		State	ZIP code
Office phone number	Fax number	Tax ID	

SECTION 4 - How to submit this form

Please send the first four pages of this form and any supporting documents to MetLife Group Disability by:

Mail:
Metropolitan Life Insurance Company
PO Box 14590
Lexington, KY 40512-4590

Fax:
1-800-230-9531

Please write your patient's claim number on any documents you send.

We're here to help

Please don't hesitate to contact us if you have any questions.

Physician: You can reach us at 1-866-463-6377, Monday through Friday, 8:00 a.m. to 11:00 p.m. Eastern time.

SECTION 5 - Insurance fraud warnings

Before signing this form, please read the warning for the state where you reside or work and, if you are submitting a claim for disability income benefits, 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 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 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and 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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia 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: A 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 and 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.

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.

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 a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

LONG TERM DISABILITY CLAIM FORM EMPLOYEE STATEMENT

MetLife

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
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.

Claim#:

Section 1: Personal Information

Name (Last, First, MI) – MUST ANSWER	Employer – MUST ANSWER	Group Report #	ID Number

Address City State Zip Code	Date of Birth (MM/DD/YY)	Sex	Social Security # MUST ANSWER
	mm/dd/yy	☐ M ☐ F	

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

Home Phone #	Work Phone #	Occupation	Marital Status	Tax Exemptions
			☐ Married ☐ Single ☐ Other	

Dependent Information:

	Name	Date of Birth	SS#
Spouse		mm/dd/yy	
Children		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	

Section 2: Claim Information

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

Is this condition work related? ☐ Yes ☐ No

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

Date of first treatment for this condition	Date Last Worked MUST ANSWER	Date Disability Began	Height	Weight
mm/dd/yy	mm/dd/yy	mm/dd/yy		

Name, address, phone number of your primary attending physician.

Name of physicians/providers who have treated you within the past 2 years.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	

Has the patient been hospitalized? ☐ Yes ☐ No If Yes, give dates from mm/dd/yy to mm/dd/yy ☐ Inpatient ☐ Outpatient
Name and address of hospital

Circle Highest Education Level Completed.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18

Degrees, Certificates, License/Skills or training obtained

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/To Dates
Salary Continuance/Sick Leave	☐	☐			mm/dd/yy mm/dd/yy
Short Term Disability	☐	☐			mm/dd/yy mm/dd/yy
Worker's Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Social Security	☐	☐			mm/dd/yy mm/dd/yy
Dependent Social Security	☐	☐			mm/dd/yy mm/dd/yy
No Fault (Income Replacement)	☐	☐			mm/dd/yy mm/dd/yy
Retirement/Pension	☐	☐			mm/dd/yy mm/dd/yy
Permanent Total Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please Identify)	☐	☐			mm/dd/yy mm/dd/yy

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	mm/dd/yy **Date**	**Claimant's Signature**	mm/dd/yy **Date**

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
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).

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.

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.

_____ mm/dd/yy _____

Name of Employee (Please Print) **Date of Birth**

Claim Number: _____ **ID 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, 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, contractholder 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 anytime 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.

_____ mm/dd/yy _____

Signature of Employee **Date**

Disability Claim Employee Statement (Continued)

Fraud Warning:

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 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 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and 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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia 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 – A 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 and 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.

Disability Claim Employee Statement (Continued)

Fraud Warning *(continued)*:

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.

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 a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

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

Signature of Employee: _____ Date:_____ mm/dd/yy

LONG TERM DISABILITY
CLAIM FORM
EMPLOYER STATEMENT

MetLife

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this claim form to expedite your claim – retain original for your records.

Claim#: _____

Section 1: Employer Information

Name of Employer - MUST ANSWER	Group Report #	Sub-Division #	Branch #

Address	City	State	ZIP Code	Employer Tax ID#

Subsidiary or Division Name	Address

Contact Person's Name	Phone #

Section 2: Employee Information

Name (Last, First, MI) - MUST ANSWER	**Social Security # - MUST ANSWER**	Date of Birth (MM/DD/YY)	Sex
		mm/dd/yy	☐ M ☐ F

Address	City	State	ZIP Code	Home Phone #

Marital Status	W4 Filing Status	Date of Hire	Current Occupation	How long at this occupation?
☐ Married ☐ Single ☐ Other	Exemptions: _____	mm/dd/yy		

Work Location Address	Employee ID #	Work Phone #

Supervisor Name	Phone #

Section 3: Claim Information

Is claim due to ☐ Injury? ☐ Illness?	Description of illness or injury (including date of accident):
Is condition work-related? ☐ Yes ☐ No	

If yes, provide name and address of Workers' Compensation Carrier.

Name _____ Address _____

Contact Person's Name _____ Phone # _____ Worker's Comp. Claim # _____

Date Last Worked MUST ANSWER	First Date of Absence	Date Returned to Work ☐ Actual ☐ Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy		

Premium Contributions		Basic Earnings (exclusive of overtime, bonus, etc.)	Average Hours Worked
Employer _____ % Employee _____ %	☐ Pre-tax ☐ Post-tax	$ _____ ☐ Hourly ☐ Weekly ☐ Monthly	Per Week

Employee's Status As Of First Day Absent If other than active, Please explain	☐ Active ☐ LOA ☐ Terminated ☐ Vacation ☐ Laid Off ☐ Retired	LTD: Date Enrollment Card Signed mm/dd/yy	If buy up: Date Enrollment Card Signed mm/dd/yy

Has employee had previous absences from work due to disability? ☐ Yes ☐ No If yes, provide dates and medical conditions

Can employee's job be modified? ☐ Yes ☐ No If yes, describe how.	Has return to work been discussed with employee? ☐ Yes ☐ No

To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the following sources:

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☐			mm/dd/yy mm/dd/yy
Short Term Disability	☐	☐			mm/dd/yy mm/dd/yy
Workers' Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Social Security	☐	☐			mm/dd/yy mm/dd/yy
Dependent Social Security	☐	☐			mm/dd/yy mm/dd/yy
No Fault (Income Replacement)	☐	☐			mm/dd/yy mm/dd/yy
Retirement/Pension	☐	☐			mm/dd/yy mm/dd/yy
Permanent Total Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please identify)	☐	☐			mm/dd/yy mm/dd/yy

Continued on following page

Section 4: Employee's Job Description

Name of Employee: _____ **Usual Days Worked** _____ **/per week**

Employee's Job Title: _____ **Hours Worked** _____ **/per week**

Social Security Number: _____ **Claim Number** _____

This section should be completed by someone who is familiar with the employee's job functions (e.g. manager or supervisor). Complete all sections. This section must be completed AND you must also attach a copy of your company's job description for the employee.

Name of Person Completing This Section:

_____ Title: _____

Signature: _____ Date: mm/dd/yy

Place an X in each of the appropriate boxes to describe the extent of the specific activity performed by this employee.

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
1. Sitting					
2. Standing					
3. Walking					
4. Bending Over					
5. Twisting					
6. Climbing					
7. Reaching Above Shoulder Level					
8. Crouching/Stooping					
9. Kneeling					
10. Balancing					
11. Pushing and Pulling					
12. Repetitive Use of Foot Control					
A. Right Foot Only					
B. Left Foot Only					
C. Both Feet					
13. Repetitive Use of Hands					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
14. Grasping					
A. Simple/Light					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
B. Firm/Strong					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
15. Fine Finger Dexterity					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					
16. Use of Head and Neck in:					
A. Static Position					
B. Twisting					
C. Looking Up					
D. Looking Down					

	Never 0% Of Time	Occasionally 1-33% Of Time	Frequently 34-66% Of Time	Continually 67-100% Of Time
17. Lifting or carrying				
A. Up to 10 lbs				
B. 11 – 20 lbs				
C. 21 – 50 lbs				
D. 51 – 100 lbs				
E. 100 + lbs				
18. Frequency of Interpersonal Relationships Necessary to Perform the Job				
19. Frequency of Stressful Situations Necessary to Perform the Job				

In the course of performing the job, the employee is required to:

	Yes	No
20. Drive cars, trucks, forklifts and/or other equipment		
21. Be around moving equipment and/or machinery		
22. Walk on uneven ground		

	Yes	No
23. Be exposed to dust, gas, or fumes		
if yes, are respirators required		
24. Be exposed to marked changes in temperature or humidity		
25. Is overtime required on a routine basis		

Continued on following page

Disability Claim Statement (Continued)

Name of Employee:_____ **Social Security Number:**_____

Fraud Warning:

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 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 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and 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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia 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 – A 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 and 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.

Fraud Warning *(continued)*:

Name of Employee:_____ **Social Security Number:**_____

Fraud Warning *(continued)*:

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.

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 a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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.

Employer's Authorized Representative

Name_____ Title:_____ Phone #_____

Signature_____ Date:_____ mm/dd/yy

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 45011
Fax 1-800-230-9531

METROPOLITAN LIFE INSURANCE COMPANY
TRAINING, EDUCATION AND EXPERIENCE

NAME: _____ **CLAIM#:** _____ **SSN:** _____

In order to continue the evaluation of your claim, we need some additional information. Please complete this form to the best of your ability and return it to us in the enclosed envelope. Feel free to use an additional sheet of paper if you need more space. If you have any questions, please do not hesitate to contact us.

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.

Training/ Educational Background

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

High School GED College Degree Graduate School

Degrees received: _____ Dates attended: mm/dd/yy

Major: _____ Minor: _____

List any other vocational or business courses attended:

School	Program	Date completed	Certificate/License obtained
		mm/dd/yy	
		mm/dd/yy	

Were you in the Armed Forces? Yes No Dates: mm/dd/yy to mm/dd/yy

Branch of service _____ Highest Rank _____ Specialty _____

Work Experience

Describe each job worked within the last 15 years. Resumes are appreciated, please include if available

From/To		Job Title	Responsibilities	Supervisory Experience Yes/No
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			

(Continued on Following Page)

Name of Employee:_____ Social Security Number:_____

Fraud Warning:

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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

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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.

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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 and 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.

Name of Employee:_____ Social Security Number:_____

Has anyone assisted you in the completion of this form? If so, have them co-sign below.

Fraud Warning *(continued)*:

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.

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Day Phone #:_____ Evening Phone #:_____

Signature_____ Date mm/dd/yy

Co-Signature:_____ Relationship:_____

PHYSICAL CAPACITY EVALUATION

MetLife

Name of Claimant:_____ **SSN:**_____

Claim No:

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Important: Have you performed, or had someone else perform, an objective evaluation of this patient's physical capabilities? _____Yes _____No.

Please complete the following items based on your evaluation of the patient and other testing results. Mark any items that you do not believe you can answer 'N/A' (not answerable). **Note:** Please complete the form in terms of your patient's **functional ability in an 8 hr. day** of activity.

The weight the patient can lift:		Occasionally (1–33%)	Frequently (34–66%)	Continuously (67–100%)	Maximum Allowed
1. Floor to waist:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				
2. Waist to shoulder:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				
3. Above Shoulder:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				

		Occasionally (1–33%)	Frequently (34–66%)	Continuously (67–100%)	Maximum Allowed
The weight the patient can carry:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				
The weight the patient can push:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				
The weight the patient can pull:	<10 lbs				
	10–20 lbs				
	21–50 lbs				
	51–100 lbs				
	over 100 lbs				

The Patient's dominant extremity is: Right_____ **Left**_____

The Patient's affected extremity is: Right_____ **Left**_____ **Not Applicable**_____

Impacted Extremity			
The patient can:	**Occasionally (1–33%)**	**Frequently (34–66%)**	**Continuously (67–100%)**
Reach above shoulder level			
Reach front and side			

Impacted Extremity		
The patient can perform the following functions:	**How many minutes in an hour?**	**How many hours in a day?**
Handling *(holding, grasping turning with hand—fingers are only involved in that they are an extension of the hand)*		
Fingering *(picking, pinching, or otherwise working primarily with fingers, not hand, wrist or arm)*		

Name of Employee_____ Social Security Number:_____

Impacted Extremity		
The patient can operate foot controls:	**How many minutes in an hour?**	**How many hours in a day?**
Right foot/leg		
Left foot/leg		

The patient can:	**Occasionally (1–33%)**	**Frequently (34–66%)**	**Continuously (67–100%)**
Bend *(bending at the waist)*			
Crouch *(bending the legs and spine)*			
Kneel			
Climb ladders			
Climb stairs			
Climb poles			
Crawl			
Balancing *(maintaining body Equilibrium to prevent falling)*			

Exposure to:	**Occasionally (1–33%)**	**Frequently (34–66%)**	**Continuously (67–100%)**
Hot environment			
Cold environment			
Weather			
Fumes/dust/gases			
Any problems with hearing?			
Any problems with vision?			
Other environmental situations? Please list:			

In an 8 hour day of activity, the patient can:	**How many minutes in an hour?**	**How many hours in a day?**
Sit		
Stand		
Walk		

Driving Activities:	**How many minutes in an hour?**	**How many hours in a day?**
Driving Automobile		
Driving heavy equipment		

If the patient needs to change positions, please describe how this should occur?

Other considerations/functional capabilities or limitations:

Additional comments:

In order to accurately evaluate your patient's functional capabilities, do you think it would be beneficial to have an in-depth evaluation of your patient's functional abilities completed (e.g. a Functional Capacity Evaluation)? ____Yes ____No

Signature of Physician: _____ Date: mm/dd/yy

Mail to: MetLife, P.O. Box 14590, Lexington KY 40512 Fax to: 1-800-230-9531

Name of Employee:_____ Social Security Number:_____

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, Maryland, Rhode Island, 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.

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

Name of Employee:_____ Social Security Number:_____

Fraud Warning *(continued)*:

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.

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.

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.

Signature of Physician_____ Date mm/dd/yy

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 45011
Fax 1-800-230-9531

Metropolitan Life Insurance Company
Physician, Medication and Insurance Information

PLEASE COMPLETE FOR PERIOD OF mm/dd/yy TO mm/dd/yy

Met Disability

Name:	Date: mm/dd/yy
Company name/Report #:	Claim #:

Name:	Name:
Specialty/Diagnosis:	Specialty/Diagnosis:
Address:	Address:
Telephone: /FAX #:	Telephone: /FAX #:
1st Treatment Date: mm/dd/yy	1st Treatment Date: mm/dd/yy

Name:	Name:
Specialty/Diagnosis:	Specialty/Diagnosis:
Address:	Address:
Telephone: /FAX #:	Telephone: /FAX #:
1st Treatment Date: mm/dd/yy	1st Treatment Date: mm/dd/yy

Name:	Name:
Specialty/Diagnosis:	Specialty/Diagnosis:
Address:	Address:
Telephone: /FAX #:	Telephone: /FAX #:
1st Treatment Date: mm/dd/yy	1st Treatment Date: mm/dd/yy

PLEASE CONTINUE ON THE BACK OF THIS FORM TO LIST MEDICATIONS AND INSURANCE INFORMATION

(Continued on Following Page)

Name of Employee:_____ Social Security Number:_____

Please List Your Pharmacy's Name, Address, and Phone Number

Name:_____ Name:_____

Address:_____ Address:_____

_____ _____

Telephone:_____ Telephone:_____

PLEASE LIST ALL MEDICATIONS

Name	Dosage	Frequency	Start Date
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy
			mm/dd/yy

Please list all medical insurance companies and/or
Workers' Compensation Carriers that covered you during the period of

mm/dd/yy to mm/dd/yy

Name:	Name:
Group #:	Group #:
Address:	Address:
Telephone:	Telephone:

(Continued on Following Page)

Name of Employee:_____ Social Security Number:_____

Fraud Warning:

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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

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Name of Employee:_____ Social Security Number:_____

Fraud Warning *(continued)*:

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Employee's Signature_____ Date mm/dd/yy

MetLife

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax 1-800-230-9531

METROPOLITAN LIFE INSURANCE COMPANY
PERSONAL PROFILE

NAME:_____ **CLAIM#:**_____ **SSN:**_____

CLAIMANT: Please describe your daily activities in the following areas. Use additional pages when necessary. Please complete this form and return it in the envelope provided as soon as possible but no later than 30 days from date of receipt. Failure to answer any of these questions may delay the initial decision or continuation of your benefits.

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.

GENERAL INFORMATION

1. Please provide us with a brief description of your present condition(s). Describe any physical and/or psychiatric/psychological limitations related to your return to work:

2. Have you been hospitalized in the last 12 months? If so, please list:

Hospital Name	Address	Dates of Admission
		mm/dd/yy
		mm/dd/yy
		mm/dd/yy

3. Please list all Attending Physicians and Specialists to which you have been referred for this condition(s):

Physician's Name	Address	Phone	Specialty

4. Do you take medication for your condition(s)? Yes_____ No _____
Please provide the following:

Medication	Dosage	How often taken	Start Date	End Date
			mm/dd/yy	mm/dd/yy
			mm/dd/yy	mm/dd/yy
			mm/dd/yy	mm/dd/yy

If you need help taking medication, please explain: _____

(Continued on Following Page)

Name of Employee:_____ Social Security Number_____

5. Please list all medical insurance companies/carriers:

Name	Group #	Address	Telephone #

6. Please indicate any testing that has been performed within the last 12 months. (CT Scan, MRI, stress test, physical/functional capacity evaluation, etc.): _____

7. Provide us with a detailed description of your daily routine: _____

8. Do you live alone? Yes_____ No _____
   If no, who lives with you? (names, relationship and ages)

9. If you have family dependents (e.g., children, parents, spouse) do they depend on you for care? If so, please explain:

10. What is your present height?_____ weight?_____

    Are you right or left handed?_____

11. What time do you get up in the morning?_____ Go to bed?_____

    Have your sleeping habits changed since your condition(s) began? Please explain: _____

    Have there been any changes in your ability to care for your personal needs and grooming? Please explain:_____

(Continued on Following Page)

Name of Employee:_____ Social Security Number_____

12. Have you tried any type of work or volunteer activity since you left work? Please give details, including names, dates, wages/compensation, duties, etc: _____

13. When do you expect to return to your last job/occupation either on a full-time or part-time basis? Please explain in detail:

14. Do you feel you could return to your job/occupation if accommodations were made? If so, please describe your accommodation needs: _____

15. Please provide us with a brief description of any other sources of income you are receiving at this time, including any Social Security or Railroad Retirement entitlements, Workers' Compensation, Pension, Self employment, No Fault, etc., and benefits received from any other insurance:

Name	Effective Dates	Amount
	mm/dd/yy	
	mm/dd/yy	
	mm/dd/yy	

HOUSEHOLD CARE

1. Have your eating habits changed since your disability began? Please explain: _____

2. Do you require assistance in preparing your meals? Please explain: _____

(Continued on Following Page)

Name of Employee:_____ Social Security Number_____

3. What type of housework do you perform? (Please circle all that apply)

Laundry | Vacuuming | Dusting | Washing dishes | Mopping | Household repairs | Lawn care | Snow shoveling

Other: _____

How often do you do this housework? _____

Have there been any changes in your ability to care for your household since your disability began?

Please explain: _____

4. Have you experienced changes in your shopping habits? Please explain: _____

5. Do you drive? Yes _____ No _____

Do you take public transportation? Yes _____ No _____

If you need assistance when you travel, who goes with you and how are you helped? _____

Has there been any change in the distance or time you travel? Please explain: _____

Has your physician restricted your travel or driving in any way? Please explain: _____

INTERESTS, HOBBIES AND SOCIAL ACTIVITIES

1. What kind of interests, hobbies or activities do you participate in? (Please circle all that apply)

Bowling | Exercising | Fishing | Walking | Knitting | Movies | Swimming | Sewing

Reading | Television | Computer | Coaching | Sports | Other: _____

How often do you do these activities? (please circle)

Daily | Twice a Week | Weekly Approx. time spent: _____

Have there been any changes in your participation level? Please explain: _____

(Continued on Following Page)

Name of Employee:_____ Social Security Number:_____

2. Are you active with family, church, social or other groups? Please explain: _____

How often do you participate in these activities? Daily Twice a Week Weekly Other:_____

What positions/offices do you hold in the club or group?

Have there been changes in your ability to take part in the above activities since your disability began?

Please explain: _____

TRAINING, EDUCATION AND EXPERIENCE

1. Training/ Educational Background

Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

High School GED College Degree Graduate School

Degrees received:_____ Dates attended:_____ mm/dd/yy

Major: _____ Minor:_____

List any other vocational or business courses attended:

School	Program	Date completed	Certificate/License obtained
		mm/dd/yy	
		mm/dd/yy	
		mm/dd/yy	

Were you in the Armed Forces? Yes No Dates: mm/dd/yy to mm/dd/yy

Branch of service_____ Highest Rank _____ Specialty_____

2. Work Experience

Describe each job worked within the last 15 years. Resumes are appreciated, please include if available.

From/To		Job Title	Responsibilities	Supervisory Experience Yes/No
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			
mm/dd/yy	mm/dd/yy			

(Continued on Following Page)

Name of Employee:_____ Social Security Number:_____

Fraud Warning:

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 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 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 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 from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Idaho, Indiana and 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.

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

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 thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee, Virginia 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 – A 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 and 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.

Name of Employee:_____ Social Security Number:_____

Has anyone assisted you in the completion of this form? If so, have them co-sign below.

Fraud Warning *(continued)*:

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.

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 a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Day Phone #:_____ Evening Phone #:_____

Signature_____ Date mm/dd/yy

Co-Signature:_____ Relationship:_____

Metropolitan Life Insurance Company

MetLife Disability, PO Box 14590, Lexington KY 40512
Fax: 1-800-230-9531

ELECTRONIC FUNDS TRANSFER REQUEST

If your claim is approved, we are pleased to offer you the security and convenience of having your benefit check deposited electronically to your bank account. Direct Deposit means no more mail delays or trips to cash your check.

- **How does direct deposit work?**
  Our bank will transfer your benefit payment directly into your bank account. We recommend this payment option because it is predictable, safe and convenient.
- **How do I sign up?**
  Enter the information requested below and forward this form to us at the address above. You may want to verify your account and transit/routing numbers with your bank to avoid delays.
- **How soon can my direct deposits begin?**
  To allow appropriate set-up, your direct deposit will typically begin within 30 days of our notification to your bank. This means you may still receive checks by mail after you send in your request. Once direct depositing begins, your funds will be deposited to your bank account and will be available to you within 4-5 business days.
- **What if I have questions?**
  Call our Customer Response Center at the number provided in your acknowledgement letter. Representatives are available Monday through Friday from 8:00 am to 11:00 pm EST.
- **What if I change banks?**
  Simply call and we will send a new request form for your completion. You may receive a paper check in the mail for one payment while we process your request.
- **Can I change my mind?**
  Yes. You can start or stop direct deposit at any time. Just write and tell us.

I authorize MetLife to send my disability payments to the Bank designated below for electronic deposit into my Account. I understand that I may terminate this arrangement at any time by writing to the MetLife address above.

If any overpayment of such disability benefits is credited to my account in error, I authorize and direct the Bank to charge my Account and to refund such overpayment to Metropolitan.

Please complete the following:

Name:

Claim Number:	Employer Name:
Type of Account: ❑ Checking ❑ Savings	Bank Account Number:
Name of Bank:	Bank Address:
Bank Routing Number:	Bank Telephone:

The first 9 numbers from the left at the bottom of your check are your Bank Routing Number or enclose a voided check.

Signature **Date:** mm/dd/yy

Metropolitan Life Insurance Company

Financial Index for Claim#_____ Claim#_____

AUTHORIZATION TO REFER ME TO A SOCIAL SECURITY REPRESENTATIVE FOR ASSISTANCE IN PURSUING SOCIAL SECURITY INSURANCE BENEFITS

I understand that Metropolitan Life Insurance Company ("MetLife") may refer me to a Social Security representative that specializes in obtaining Social Security Disability Insurance benefits during the course of my claim for disability benefits under my employer's disability benefit plan to assist me in pursuing Social Security Disability Insurance benefits.

I understand that as a result of any referral, I may be contacted by a Social Security representative, but I am under no obligation to retain a Social Security representative's services to pursue Social Security Disability Insurance benefits.

Therefore, to assist me in pursuing Social Security Disability Insurance benefits, I authorize MetLife to make a referral and disclose to a Social Security representative that specializes in obtaining Social Security Disability Insurance benefits the following information: my name, address, telephone number, and Social Security number; the status of my claim (if any) for Social Security Disability Insurance benefits; and the fact that I have a claim for disability benefits under my employer's disability benefit plan, the claim number for such claim, and the identity of my employer.

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. If I do not, it will be valid for 12 months.

A photocopy of this authorization is as valid as the original form and I have a right to receive a copy of this authorization on request.

_____ _____

Name of Employee SSN

_____ mm/dd/yy

Signature of Employee Date

Please sign & mail this form directly to:

Metropolitan Life Insurance Company
MetLife Disability
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

TO: Social Security Administration

Consent for Release of Information

PO Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

Name	Date of Birth	Social Security Number
	mm/dd/yy	

Claim Number

I hereby authorize the Social Security Administration to release information or records about me and family members receiving benefits on my Master Beneficiary Record (also known as a FACT query) to: **Metropolitan Life Insurance Company ("MetLife")**, or its affiliates, subsidiaries or designated representatives.

I want this information released to document my Long Term Disability claim and/or to determine the benefits payable under the provisions of the policy under which I am insured. Please provide the following information:

__XX__ FACT Query (Full Account Query)

I understand the FACT query includes all personal and benefit information regarding myself and family members who applied for Social Security benefits on my record. The information contained on this record may include and is not limited to: eligibility and entitlement to benefits on this or any other record, Social Security number, date of birth, address, telephone number, direct deposit banking data, monthly benefit amounts, benefit rate changes, worker's compensation, public disability and annuity information, Medicare data, citizenship information, history of benefits payable and amounts paid, overpayment and underpayment of benefits on the record, work information, prisoner data, Supplemental Security Income data, tax withholding, garnishment of benefits, special payments and messages, and attorney fees.

I understand that a photocopy of facsimile of this consent is as valid as the original. This authorization will be valid for two years from date of signature. I understand that **MetLife** may share this information with third parties as permitted by law.

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Signature of insured or guardian	Relationship to insured if signed by the guardian

Date
mm/dd/yy

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

LONG TERM DISABILITY BENEFICIARY DESIGNATION

Please read Instructions on next page before completing this form. Do not erase or attempt to make corrections; use a new form.

Name of Employer _____ Name of Employee _____

Employee's Long Term Disability Claim Number. _____ Employee's Social Security No. _____

I hereby designate the following individual(s) as primary beneficiary(ies) and contingent beneficiary(ies) (if any) in the event of my death during the period in which I am receiving Long Term Disability benefits under the Claim Number above. This beneficiary designation will be automatically revoked on the date that my Long Term Disability benefits under the claim number above, end.

Primary Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
		mm/dd/yy		
		mm/dd/yy		
		mm/dd/yy		
Payment will be made in equal shares or all to the survivors unless otherwise indicated.			**TOTAL:**	100%

In the event said primary beneficiary(ies) predecease(s) me, I designate as contingent beneficiary(ies)

Contingent Beneficiary Designation

Full Name (Last, First, Middle Initial)	Relationship	Date of Birth	Address (Street, City, State, Zip)	Share %
		mm/dd/yy		
		mm/dd/yy		
		mm/dd/yy		
Payment will be made in equal shares or all to the survivors unless otherwise indicated.			**TOTAL:**	100%

If no beneficiary or contingent beneficiary designated shall be living following my death, the amount payable by reason of my death shall be payable as provided by the applicable Long Term Disability Income Insurance Plan ("Plan").

Note: See Next Page for Important Information

❒ **Trust(ee) Designation** (applies only if a trust has been created in an executed trust agreement)

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code _____

and successor(s) in trust, as Trustee(s) under _____

("Title of Agreement")

Dated mm/dd/yy executed by me and said Trustee(s).

MetLife shall not be responsible for the application or disposition of the proceeds by said Trustee(s), and the receipt of the proceeds by said Trustee(s) shall be full discharge of the liability of MetLife under the Plan.

It is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at my death, the beneficiary shall be **My Estate,** and payment to my legal representative based on such proof shall be full discharge of liability of MetLife under the Plan or certificate.

❒ **Trust(ee) (Under Will) Designation** (applies only if a trust has been set forth in your Will)

The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate **My Estate** as beneficiary and any payment made in good faith to the legal representative of my estate shall be full discharge of the liability of MetLife under the Group Policy.

I reserve the right to change the designated beneficiary(ies) at any time without (his/her/their) consent.

(Please Print)

_____ _____
Name of Insured Daytime Phone No.

_____ _____ _____ _____
Street Address City State Zip Code

_____ mm/dd/yy
Signature of Insured Date Signed

Submit Completed Form to MetLife and Retain a Copy for Your Records

GENERAL BENEFICIARY INFORMATION

You may find the following definitions helpful in completing your Beneficiary Designation form.

Primary Beneficiary: You primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Contingent Beneficiary: Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease(s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

Trust(ee) Designation: If you plan to have the insurance proceeds distributed through a Trust, you should complete this section with the appropriate information. Your Trust(ee) will be held fully responsible for the application for and disposition of the insurance proceeds. **This section should only be used if you have a legally drawn inter vivos trust agreement or an appropriate Trust(ee) is designated under your Last Will and Testament. If you complete this section, do NOT complete the Primary or Contingent Beneficiary sections.**

An inter vivos trust is a trust established during the life of the trustor (the person who creates the trust) for the benefit of the trustor or other living persons.

INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION

1. Fill in the insured's Name of Employer, Long Term Disability claim number and Social Security Number at the top of the form. At the bottom of the form, fill in the name of the insured person or owner (if assigned), the daytime phone number, address, and sign and date the form.
2. Fill in the Primary Beneficiary(ies) and Contingent Beneficiary(ies), if any. For each Primary and Contingent Beneficiary listed, enter the relationship (when the relationship of the beneficiary is other than by blood or marriage, the relationship should be shown as "Nonrelative"), date of birth, address(es) (permanent residence) and percentage of share (all shares must add up to 100%).
3. If you wish to name a Trust(ee) as beneficiary, complete one of the two Trust(ee) Designations **instead** of the Primary and Contingent Beneficiary sections. If the trust is an inter vivos trust, check only the first Trust(ee) Designation box, and complete the top Trust(ee) designation. You should enter (1) the name and address of the Trust(ee); (2) the Title of the Agreement; and (3) the date of its execution. **NOTE: AN INTER VIVOS TRUST MUST BE A LEGALLY DRAWN AGREEMENT.**

If you wish to make a Trust(ee) under Will Designation, check only the second Trust(ee) Designation box. **NOTE: A TRUST(EE) UNDER WILL (OR TESTAMENTARY TRUST(EE) MUST BE ESTABLISHED UNDER THE LEGALLY DRAWN LAST WILL AND TESTAMENT OF THE INSURED OR OWNER (IF ASSIGNED).**

4. You, the owner of the coverage should sign and date the form in the spaces provided. Retain a copy for your records.
5. Give the completed form to the MetLife.

If you wish to name more beneficiaries than this form provides for, secure an additional copy. Complete your list of beneficiaries on that form. Attach the additional form to the first, indicating clearly on **each** form the number of additional forms attached. For example, if three forms are used, number the forms as follows: 1 of 3, 2 of 3 and 3 of 3.

It is important that you review your beneficiary designation periodically to ensure that the beneficiary information you supplied is up to date.

You may change or revoke your beneficiary designation at any time by completing a new Beneficiary Designation form.

This Beneficiary Designation is pertinent to the Long Term Disability claim specified, and is automatically revoked on the date that your Long Term Disability benefits, under the claim number above, end.