DISABILITY CLAIM FOR ACCIDENT & SICKNESS (A&S)/ SHORT TERM DISABILITY (STD)/SALARY CONTINUANCE

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. Please print clearly.
2. Please sign – a) bottom of this page and b) Fraud Statement.
3. Faxing this claim form will expedite receipt and eliminate your need to mail it.

Customer # 173563

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: To Be Completed by the Employer

Name of Employer | Group Report # 173565 | Sub-Code # (Sub-Division) 0001 | Sub-Point # (Branch) 0001

Address | City | State | Zip Code | Subsidiary or Division Name

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

Contact Person's Name | Phone #

Contact Person's E-mail Address | FAX #

Employee Name (First, MI, Last) | Social Security No. | Employee ID #

Date of Hire mm/dd/yy | Job Title | Job Class ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Work Location Address | Work Phone # | Home Phone #

Supervisor Name | Supervisor's E-Mail Address | Phone #

Is condition work related? ☐ Yes ☐ No. If yes, provide: W/C Carrier Name

W/C Contact Person's Name | Phone# | Worker's Comp Claim #

Date Last Worked mm/dd/yy | First Date of Absence mm/dd/yy | Date Returned To Work mm/dd/y ☐ Actual ☐ Estimated | Eff. Date of Coverage mm/dd/yy | Basic Earnings (exclusive of overtime, bonus, etc.) $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annual

Premium contributions Employer % Employee % ☐ Pre-Tax ☐ Post-Tax | Benefit Amount | Payroll Classification ☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Union ☐ Non Union ☐ Other

Employee's Status As Of First Day Absent ☐ Active ☐ LOA ☐ Terminated ☐ Vacation ☐ Laid Off ☐ Retired | Hours Worked Per Week ☐ Full Time ☐ Part Time | Scheduled Work Week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su | Is work week regular or variable

If other than Active, please explain

If STD buy up, date enrollment card signed mm/dd/yy | LTD Coverage? ☐ Yes ☐ No

Can employee's job be modified/accommodated? ☐ Yes ☐ No If yes, please describe. | 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
Workers' Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please identify)	☐	☐			mm/dd/yy mm/dd/yy

Provide weekly deduction amounts, if applicable:

	Pre Tax	Post Tax	$ Weekly Amount
Medical	☐	☐	
Life	☐	☐	
Dental	☐	☐	
LTD	☐	☐	
Other (Please identify)	☐	☐	

Authorizing Signature | Date mm/dd/yy

***Contact MetLife at 888-444-1433 for any questions you have on completing this form.**
Some services in connection with your Disability Claim may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

Section 2: To Be Completed by Employee

Name (First, MI, Last)	Social Security #	ID Number	Date of Birth (MM/DD/YY)	Gender
			mm/dd/yy	☐ M ☐ F

Address	City	State	Zip Code	E-mail Address

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

Home Phone #	Marital Status	Federal Tax Status	Tax Exemptions (Number)	Date Disability Began
	☐ Married ☐ Single ☐ Other	☐ Married ☐ Single		mm/dd/yy

Is your disability due to ☐ Illness? ☐ Injury/Accident? If due to injury/accident, provide Date mm/dd/yy, Time hh:mm AM ☐ PM ☐
Provide Details (Where and How)

Is this condition work related? ☐ Yes ☐ No | Automobile Related? ☐ Yes ☐ No

Name of physicians/providers who have treated you for this condition within the past 12 months

Name of Physician/Provider	Phone Number	Dates of Treatment	Physician Specialty
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	

Please describe what prevents you from performing the duties of your job.

Section 3: To Be Completed by Attending Physician

This report is to assist us in making a disability determination that impacts income replacement for your patient. A MetLife claim representative may telephone your office if additional information is needed

Patient Name	Date Disability Began	Expected Return to Work Date
	mm/dd/yy	mm/dd/yy

Initial date of treatment for this disability	Most recent date of treatment	Is condition work-related?
mm/dd/yy	mm/dd/yy	☐ Yes ☐ No

Primary Diagnosis Code _____ Diagnosis _____

Secondary Diagnosis Code _____ Diagnosis _____

Objective Findings:

CPT4	Procedure	Date
		mm/dd/yy

If pregnancy, delivery date mm/dd/yy ☐ Expected mm/dd/yy ☐ Actual mm/dd/yy Type of delivery

If patient has been hospitalized ☐ Inpatient ☐ Outpatient Admitted mm/dd/yy Discharged mm/dd/yy

Treatment Plan: ☐ Additional Testing ☐ Medication ☐ Therapy ☐ Surgery ☐ Hospitalization ☐ Referral
Other (Describe)

Medications prescribed (names, dosages)

Is patient able to work with job modifications or restrictions? (please be specific):

Signature	Specialty	Tax ID #

Street Address

City/State/Zip

Date mm/dd/yy

E-mail Address	Telephone #	Fax #

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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**

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)*:

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.

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

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

Signature of Employer's Representative _____ **Date:** mm/dd/yy

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