CLAIM NUMBER

Metropolitan Life Insurance Company

# STATEMENT OF CLAIM

## FOR

## ACCIDENTAL DISMEMBERMENT BENEFITS

MetLife®

MetLife
SBC Life Claims
P.O. Box 6122
Utica, NY 13504-6122

## TO BE COMPLETED BY THE INSURED

(Please answer all questions)

1. Insured's name (print) ..... Age .....
   (Phone - Area Code & No.)
2. Present address .....
   (Number) (Street) (City) (State) (Zip Code)
3. When did the accident happen? Date ..... at ..... (Hour) { a.m. / p.m.
4. Where did the accident happen? City .....State .....
5. Give a brief description of the accident .....

.....

I authorize the physician to release any information requested with respect to this Claim.
I certify that the information I furnished to support this claim is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Date ..... Signed .....

## TO BE COMPLETED BY THE EMPLOYER

(Please answer all questions)

1. Employee's name ..... Certificate No. ..... Group No. .....
2. Branch No. ..... Sub Code No. .....
3. Amount of Accidental Dismemberment Benefit, (Full) $ ..... (Half) $ ..... Issue Date .....
4. If this coverage has been canceled, give the date and reason .....
5. (a) Date last worked .....

   (b) Date returned to work .....
6. Has this claim been considered in connection with worker's compensation coverage? ☐ Yes ☐ No

   If "Yes", what is the present status of the compensation claim? .....
7. Give any information which might assist the Company in consideration of this claim. .....

.....

8. Please attatch (a) copy of your accident report and any newsletter clippings giving details of the accident.
   (b) copy of the employee's insurance record cards.

Date .....

Employer .....
(Name & Address) (Phone - Area Code & No.)

Signed By .....

Title .....

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

1. Name of patient _____ Age _____

2. (a) Date first consulted on account of the injury described _____

   (b) Date of last treatment _____

3. Describe the exact nature, location, and extent of all injuries sustained _____

**TO BE COMPLETED ONLY FOR LIMB AMPUTATIONS**

4. (a) Which limbs were severed or amputated?

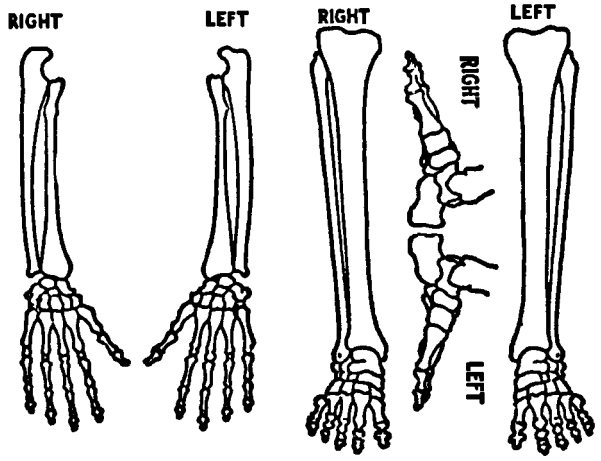
   (b) State the dates on which the severances or amputations occured.

   (c) State the exact point at which the amputation was performed or the severance occured with respect to each limb lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

5. State the cause of the amputations.

6. Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined.

7. Please give the names of such other physicians as have attended this patient, and the dates of their first and last treatments as reported to you.




**TO BE COMPLETED ONLY FOR LOSS OF VISION**

4. Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

   (a) Date _____

   (b) (Snellen Notations)

| | Uncorrected | Corrected |
|---|---|---|
| O.D.v. | | |
| O.S.v. | | |

5. Give the date and vision found on last eye examination.

   (a) Date _____

   (b) (Snellen Notations)

| | Uncorrected | Corrected |
|---|---|---|
| O.D.v. | | |
| O.S.v. | | |

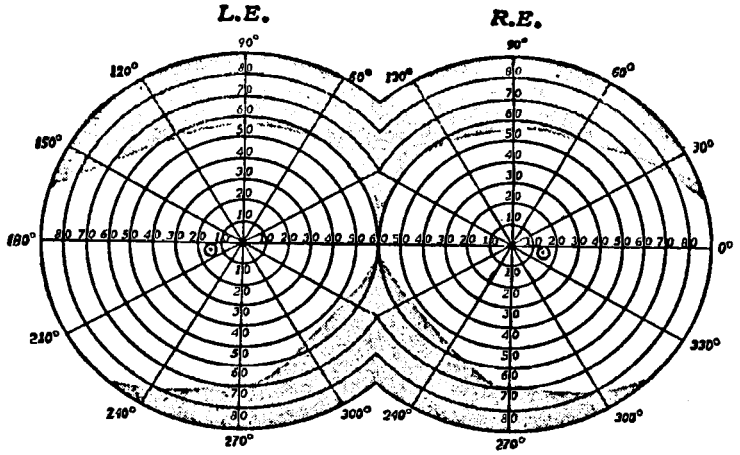
6. State the cause of loss of vision.

7. Indicate whether recovery or useful vision is possible by operation or treatment.

   O.D. ☐ Operation ☐ Treatment

   O.S. ☐ Operation ☐ Treatment

7a. If fields of vision are contracted, show contraction on chart below.




8. (a) Was the injury described solely responsible for the loss? _____

   (b) If not, give the particulars of any contributing cause or causes _____

Signed _____
(Attending Physician)

Address _____

Date _____

Phone No. _____