Indicate type of claim

☐ A&S/STD/Salary Continuance ☐ LTD

Disability Claim Employee Statement

MetLife®
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

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.

Section 1: Personal Information

Name (Last, First, MI) - **MUST ANSWER**	Employer - **MUST ANSWER**	Group Report #	Social Security # - **MUST ANSWER**

Address	City	State	Zip Code	Date of Birth (MM/DD/YY)	Sex
					☐ M ☐ F

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

Dependent Information:

	Name	Date of Birth	SS#
Spouse			
Children			

Section 2: Claim Information

Is your disability due to ☐ Injury/Accident? ☐ Illness? ☐ Pregnancy? If due to injury/accident, give date, time and details. (When, Where, How)

Is this condition work related? ☐ Yes ☐ No | If condition is due to pregnancy, what is your estimated delivery date? _____

Date of first treatment for this condition	Date Last Worked - **MUST ANSWER**	Date Disability Began	Height	Weight

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

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

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason For Visit
		From To	
		From To	
		From To	

Have you been hospitalized for this condition? ☐ Yes ☐ No If yes, give dates from _____ to _____ ☐ 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	☐	☐			
Short Term Disability	☐	☐			
Workers' Compensation	☐	☐			
State Disability	☐	☐			
Social Security	☐	☐			
Dependent Social Security	☐	☐			
No Fault (Income Replacement)	☐	☐			
Retirement/Pension	☐	☐			
Permanent Total Disability	☐	☐			
Other (Please Identify)	☐	☐			

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Name (Last, First, Middle Initial)	Social Security #	Report #	Claim #

Agreement To Reimburse Overpayment Of Short Term Disability Benefits

I agree to reimburse Metropolitan Life Insurance Company (MetLife) and/or my employer's plan for any overpayments of disability income benefits I receive under my employer's plan. I agree that, among other things, an overpayment will arise to the extent I receive benefits from my employer's plan that are later determined to be payable to me under (1) a Workers' Compensation Law; (2) an Occupational Disease law; and/or (3) another similar law. When an overpayment arises, I agree to reimburse MetLife and/or my employer's plan for the overpayment from the proceeds I receive under such a law. If necessary, I also permit my employer to deduct the overpayment from my salary or any other benefits that may become due me, (and if appropriate, to reimburse MetLife) to the extent permissible by law.

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 Workers' Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

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

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.

2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.

3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.

4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.

5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement .

6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.

7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

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

Witness Signature	Date	Claimant's Signature	Date

Continued on Next Page

Claim Number: _____

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Authorization To Furnish Medical Information

Authorization – For underwriting and claim purposes, **I permit:** any physician or other medical practitioner, hospital, clinic, other medical related facility, employers and group policyholders, contractholders or benefit plan administrators:

To disclose to MetLife and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all medical data that you may have on the person proposed for coverage. I specifically authorize disclosure of findings on: medical care or surgery; psychiatric or psychological care or examinations; 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 to MetLife but only in accordance with laws and regulations as apply to me.**

I understand that I may revoke this authorization at any time. If I do not, it will be valid throughout the duration of my claim for benefits. A photocopy of this authorization is as valid as the original form.

The employee must sign in all cases.

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

_____ _____
Signature of Employee **Date**

You have a right to receive a copy of this authorization on request.

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Disability Claim Employee Statement (Continued)

Fraud Warning:

If you are insured under a policy issued in one of the following states, **or** if you reside in one of the following states, one of the following state warnings may apply to you:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

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

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

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

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

Oregon: 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 any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

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

If you are covered under a self-funded plan or insured under a policy issued in any state other than those listed above, **or** if you reside in any state other than those listed above, then the following warning may apply to you:

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 any 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: _____