Indicate type of claim

☐ A&S/STD/Salary Continuance ☐ LTD

Disability Claim Employer 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. Sign the claim form.
3. Fax this form to expedite your claim - retain original for your records.

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 ☐ M ☐ F

Address	City	State	Zip Code	Home Phone # ( ) -

Marital Status ☐ Married ☐ Single ☐ Other	W 4 Filing Status_____ Exemptions_____	Date of Hire	Current Occupation	How long at this occupation?

Work Location Address	Work Phone # ( ) -

Supervisor Name	Phone # ( ) -

Section 3: Claim Information

Is claim due to ☐ Injury? ☐ Illness? ☐ Pregnancy?

Is condition work-related? ☐ Yes ☐ No

Description of illness or injury (including date of accident):

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

Name _____ Address _____

_____ 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

Premium contributions ☐ Pre-Tax
Employer _____% Employee _____% ☐ Post-Tax

Basic Earnings (exclusive of overtime, bonus, etc.)
$_____ ☐ Hourly ☐ Weekly ☐ Monthly

Average Hours Worked Per Week

Employee's Status As Of First Day Absent ☐ Active ☐ Vacation
If other than Active, please explain ☐ LOA ☐ Laid Off
☐ Terminated ☐ Retired

LTD Only:
Date Enrollment Card Signed

If buy up:
Date Enrollment Card Signed

LTD Only: 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	☐	☐			
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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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: _____

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 or 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		

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Disability Claim Employer Statement (Continued)

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

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.

Employer's Authorized Representative

Name _____ Title_____ Phone #_____

Signature _____ Date _____