

**LONG TERM DISABILITY  
CLAIM FORM  
EMPLOYEE STATEMENT**



Metropolitan Life Insurance Company  
P.O. Box 14590  
Lexington, KY 40511-4590  
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.

<b>Section 1: Personal Information</b>					
<b>Name (Last, First, MI) – MUST ANSWER</b>		<b>Employer – MUST ANSWER</b>		<b>Group Report #</b>	<b>Social Security # MUST ANSWER</b>
Address		City	State	Zip Code	Date of Birth (MM/DD/YY) Sex <input type="checkbox"/> M <input type="checkbox"/> F
Home Phone # ( ) -	Work Phone # ( ) -	Occupation	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		Tax Exemptions
Department Information:					
Name		Date of Birth		SS#	
Spouse					
Children					
<b>Section 2: Claim Information</b>					
Is your disability due to <input type="checkbox"/> Injury/Accident? <input type="checkbox"/> Illness?			If due to injury/accident, give date, time and details. (When, Where, How)		
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Date of first treatment for this condition	<b>Date Last Worked MUST ANSWER</b>	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.					
<u>Name of Physician/Provider</u>	<u>Phone Number</u>	<u>Dates of Treatment</u>		<u>Reason for Visit</u>	
		From	To		
		From	To		
		From	To		
Has the patient been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give dates from _____ to _____ <input type="checkbox"/> Inpatient <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the following information.					
	Applied for	Receiving	\$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
No Fault (Income Replacement)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Retirement/Pension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Permanent Total Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other (Please Identify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

\_\_\_\_\_  
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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date



Metropolitan Life Insurance Company  
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Lexington, KY 40511-4590  
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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).**

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.**

\_\_\_\_\_  
Name of Employee (Please Print)

\_\_\_\_\_  
Social Security Number

Claim 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), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, 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/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its disability benefit plan, 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 in its capacity as administrator of its benefit plans 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 40511-4590, 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.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

## 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.

**Massachusetts:** 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 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.

**Kansas, Oregon, Washington and Vermont:** 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 may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

**Puerto Rico:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**Virginia:** 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.

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 may be a crime and may subject such person to criminal and civil penalties.

Name of Employee (Please Print): \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_