

**LONG TERM DISABILITY  
CLAIM FORM  
EMPLOYER 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. Sign the claim form.
3. Fax this claim form to expedite your claim – retain original for your records.

<b>Section 1: Employer Information</b>					
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 #	
<b>Section 2: Employee Information</b>					
Name (Last, First, MI) - MUST ANSWER			Social Security # - MUST ANSWER		Date of Birth (MM/DD/YY) Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State	ZIP Code	Home Phone #
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		W4 Filing Status _____ Exemptions: _____	Date of Hire	Current Occupation	How long at this occupation?
Work Location Address					Work Phone #
Supervisor Name					Phone #
<b>Section 3: Claim Information</b>					
Is claim due to <input type="checkbox"/> Injury? <input type="checkbox"/> Illness?		Description of illness or injury (including date of accident):			
Is condition work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, provide name and address of Workers' Compensation Carrier.					
Name _____		Address _____			
Contact Person's Name _____		Phone # _____		Worker's Comp. Claim # _____	
Date Last Worked <b>MUST ANSWER</b>	First Date of Absence	Date Returned to Work <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate
Premium Contributions Employer _____% Employee _____%		<input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax	Basic Earnings (exclusive of overtime, bonus, etc.) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Average Hours Worked Per Week
Employee's Status As Of First Day Absent If other than active, Please explain		<input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Retired	LTD: Date Enrollment Card Signed		If buy up: Date Enrollment Card Signed
Has employee had previous absences from work due to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates and medical conditions					
Can employee's job be modified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe how.				Has return to work been discussed with employee? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Workers' 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"/>	_____	_____	_____

**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						Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+		0	1-2	3-4	5-6	7-8+
1. Sitting						14. Grasping					
2. Standing						A. Simple/Light					
3. Walking						1. Right Hand Only					
4. Bending Over						2. Left Hand Only					
5. Twisting						3. Both Hands					
6. Climbing						B. Firm/Strong					
7. Reaching Above Shoulder Level						1. Right Hand Only					
8. Crouching/Stooping						2. Left Hand Only					
9. Kneeling						3. Both Hands					
10. Balancing						15. Fine Finger Dexterity					
11. Pushing and Pulling						A. Right Hand Only					
12. Repetitive Use of Foot Control						B. Left Hand Only					
A. Right Foot Only						C. Both Hands					
B. Left Foot Only						16. Use of Head and Neck in:					
C. Both Feet						A. Static Position					
13. Repetitive Use of Hands						B. Twisting					
A. Right Hand Only						C. Looking Up					
B. Left Hand Only						D. Looking Down					
C. Both Hands											

	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		

## Disability Claim 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.

**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.**

Employer's Authorized Representative

Name \_\_\_\_\_ Title: \_\_\_\_\_ Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_