

**DISABILITY CLAIM FOR
ACCIDENT & SICKNESS (A&S)/
SHORT TERM DISABILITY (STD)/SALARY CONTINUANCE**



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. Please print clearly.
2. Please sign – a) bottom of this page and b) Fraud Statement.
3. Faxing this claim form will expedite receipt and eliminate your need to mail it.

Section 1: To Be Completed by the Employer					
Name of Employer		Group Report #	Sub-Code # (Sub-Division)	Sub-Point # (Branch)	
Address		City	State	Zip Code	Subsidiary or Division Name
Contact Person's Name				Phone #	
Contact Person's E-mail Address				FAX #	
Employee Name (First, MI, Last)			Social Security No.	Employee ID #	
Date of Hire	Job Title		Job Class <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy		
Work Location Address			Work Phone #	Home Phone #	
Supervisor Name			Supervisor's E-Mail Address	Phone #	
Is condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, provide: W/C Carrier Name _____					
W/C Contact Person's Name		Phone#		Worker's Comp Claim #	
Date Last Worked	First Date of Absence	Date Returned To Work <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Eff. Date of Coverage	Basic Earnings (exclusive of overtime, bonus, etc.) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
Premium contributions Employer _____% Employee _____%		<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	Benefit Amount	Payroll Classification <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non Union <input type="checkbox"/> Other _____	
Employee's Status As Of First Day Absent		<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	Hours Worked Per Week _____	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time Scheduled Work Week <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su Is work week regular _____ or variable _____	
If other than Active, please explain _____					
If STD buy up, date enrollment card signed _____				LTD Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Can employee's job be modified/accommodated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe. _____				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"/>	_____	_____	_____
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other (Please identify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Provide weekly deduction amounts, if applicable:					
	Pre Tax	Post Tax	\$ Weekly Amount		
Medical	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Life	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Dental	<input type="checkbox"/>	<input type="checkbox"/>	_____		
LTD	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Other (Please identify) _____	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Authorizing Signature				Date	

*Contact MetLife at 888-444-1433 for any questions you have on completing this form.

Section 2: To Be Completed by Employee					
Name (First, MI, Last)		Social Security #		Date of Birth (MM/DD/YY)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address		City	State	Zip Code	E-mail Address
Home Phone #	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other		Federal Tax Status <input type="checkbox"/> Married <input type="checkbox"/> Single		Tax Exemptions (Number)
Date Disability Began					
Is your disability due to <input type="checkbox"/> Illness? <input type="checkbox"/> Injury/Accident? If due to injury/accident, provide Date _____, Time _____ AM <input type="checkbox"/> PM <input type="checkbox"/>					
Provide Details (Where and How)					
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No			Automobile Related? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of physicians/providers who have treated you for this condition within the past 12 months					
<u>Name of Physician/Provider</u>		<u>Phone Number</u>		<u>Dates of Treatment</u>	
				From To	
				From To	
Physician Specialty					
Please describe what prevents you from performing the duties of your job.					
Section 3: To Be Completed by Attending Physician					
This report is to assist us in making a disability determination that impacts income replacement for your patient. A MetLife claim representative may telephone your office if additional information is needed					
Patient Name			Date Disability Began		Expected Return to Work Date
Initial date of treatment for this disability		Most recent date of treatment		Is condition work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary ICD-9 _____ Diagnosis _____					
Secondary ICD-9 _____ Diagnosis _____					
Objective Findings:					
CPT4		Procedure			Date
If pregnancy, delivery date _____ <input type="checkbox"/> Expected _____ <input type="checkbox"/> Actual _____ Type of delivery _____					
If patient has been hospitalized <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Admitted _____ Discharged _____					
Treatment Plan: <input type="checkbox"/> Additional Testing <input type="checkbox"/> Medication <input type="checkbox"/> Therapy <input type="checkbox"/> Surgery <input type="checkbox"/> Hospitalization <input type="checkbox"/> Referral _____					
Other (Describe)					
Medications prescribed (names, dosages)					
Is patient able to work with job modifications or restrictions? (please be specific):					
Signature			Specialty		Tax ID #
Street Address _____					Date
City/State/Zip _____					
E-mail Address			Telephone #		Fax #



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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 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 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 Statement (Continued)

Fraud Warning:

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 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.

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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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: _____

Signature of Employer's Representative _____	Date: _____
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Signature of Physician _____	Date: _____
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