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

MetLife®
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
mm/dd/yy		☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Work Location Address	Work Phone #	Home Phone #

Supervisor Name	Supervisor's E-Mail Address	Phone #

Is condition work related? ☐ Yes ☐ 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 ☐ Actual ☐ Estimated	Eff. Date of Coverage	Basic Earnings (exclusive of overtime, bonus, etc.) $ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annual
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	

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

Benefit Amount

Payroll Classification ☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Union ☐ Non Union ☐ Other_____

Employee's Status As Of First Day Absent ☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Terminated ☐ Retired

Hours Worked Per Week_____ ☐ Full Time ☐ Part Time

Scheduled Work Week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Is work week regular_____ or variable_____

If other than Active, please explain

If STD buy up, date enrollment card signed mm/dd/yy LTD Coverage? ☐ Yes ☐ No

Can employee's job be modified/accommodated? ☐ Yes ☐ No If yes, please describe.

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	☐	☐			mm/dd/yy mm/dd/yy
Workers' Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please identify)_____	☐	☐			mm/dd/yy mm/dd/yy

Provide weekly deduction amounts, if applicable:

	Pre Tax	Post Tax	$ Weekly Amount
Medical	☐	☐	
Life	☐	☐	
Dental	☐	☐	
LTD	☐	☐	
Other (Please identify)_____	☐	☐	

Authorizing Signature	Date
	mm/dd/yy

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***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
		mm/dd/yy	☐ M ☐ F

Address	City	State	Zip Code	E-mail Address

Home Phone #	Marital Status	Federal Tax Status	Tax Exemptions (Number)	Date Disability Began
	☐ Married ☐ Single ☐ Other	☐ Married ☐ Single		mm/dd/yy

Is your disability due to ☐ Illness? ☐ Injury/Accident? If due to injury/accident, provide Date mm/dd/yy, Time hh:mm AM ☐ PM ☐

Provide Details (Where and How)

Is this condition work related? ☐ Yes ☐ No | Automobile Related? ☐ Yes ☐ No

Name of physicians/providers who have treated you for this condition within the past 12 months

Name of Physician/Provider	Phone Number	Dates of Treatment	Physician Specialty
		From mm/dd/yy To mm/dd/yy	
		From mm/dd/yy To mm/dd/yy	

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
	mm/dd/yy	mm/dd/yy

Initial date of treatment for this disability	Most recent date of treatment	Is condition work-related?
mm/dd/yy	mm/dd/yy	☐ Yes ☐ No

Primary ICD-9 ____.____ Diagnosis____

Secondary ICD-9____.____ Diagnosis____

Objective Findings:

CPT4	Procedure	Date
		mm/dd/yy

If pregnancy, delivery date mm/dd/yy ☐ Expected mm/dd/yy ☐ Actual mm/dd/yy Type of delivery____

If patient has been hospitalized ☐ Inpatient ☐ Outpatient Admitted mm/dd/yy Discharged mm/dd/yy

Treatment Plan: ☐ Additional Testing ☐ Medication ☐ Therapy ☐ Surgery ☐ Hospitalization ☐ 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____ mm/dd/yy

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**

mm/dd/yy **Date**

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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:** mm/dd/yy

Signature of Employer's Representative _____ **Date:** mm/dd/yy

Signature of Physician _____ **Date:** mm/dd/yy