LONG TERM DISABILITY
CLAIM FORM
EMPLOYEE STATEMENT

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.
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.

Section 1: Personal Information

Name (Last, First, MI) – MUST ANSWER	**Employer** – MUST ANSWER	Group Report #	**Social Security #** MUST ANSWER
Address / City / State / Zip Code		Date of Birth (MM/DD/YY)	Sex ☐M ☐F

Home Phone # ( ) –	Work Phone # ( ) –	Occupation	Marital Status ☐Married ☐Single ☐Other	Tax Exemptions

Department Information:

	Name	Date of Birth	SS#
Spouse			
Children			

Section 2: Claim Information

Is your disability due to ☐Injury/Accident? ☐Illness?

Is this condition work related? ☐Yes ☐No

If due to injury/accident, give date, time and details. (When, Where, How)

Date of first treatment for this condition	**Date Last Worked** MUST ANSWER	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.

Name of Physician/Provider	Phone Number	Dates of Treatment	Reason for Visit
		From To	
		From To	
		From To	

Has the patient been hospitalized? ☐Yes ☐No If Yes, give dates from_____ to_____ ☐Inpatient ☐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? ☐Yes ☐No If yes, provide the following information.

	Applied for	Receiving	$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	☐	☐			
Short Term Disability	☐	☐			
Worker's Compensation	☐	☐			
State Disability	☐	☐			
Social Security	☐	☐			
Dependent Social Security	☐	☐			
No Fault (Income Replacement)	☐	☐			
Retirement/Pension	☐	☐			
Permanent Total Disability	☐	☐			
Other (Please Identify)	☐	☐			

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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**

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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 for 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 diseases 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 any time 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**

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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 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 and 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 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.

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

Signature of Employee:_____ Date:_____

LONG TERM DISABILITY CLAIM FORM EMPLOYER STATEMENT

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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	W4 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?	Description of illness or injury (including date of accident):
Is condition work-related? ☐ Yes ☐ 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 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 Employer_____% Employee_____% ☐ Pre-tax ☐ 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 If other than active, Please explain	☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Terminated ☐ Retired	LTD: Date Enrollment Card Signed	If buy up: Date Enrollment Card Signed

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)	☐	☐			

Continued on following page

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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 and 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		

Continued on following page

Disability Claim Statement (Continued)

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

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Employer's Authorized Representative

Name_____ Title:_____ Phone #_____

Signature_____ Date:_____