MetLife

Accident & Sickness (A&S)/Short Term Disability (STD)/Salary Continuance

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Complete all applicable areas of this form that apply to you (Employer, Employee and Physician/Provider) Please print clearly.
- Your signature is required at the end of your section: Employer see SECTION 1, Employee see SECTION 2, and Physician/Provider see SECTION 3.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SECTION 1: To Be Completed by the Employer

Employer Name	Subsidiary or Division Name

Group Report Number	Sub-Code Number *(Sub-Division)*	Sub-Point Number *(Branch)*

Address	City	State	ZIP

We require a street address for our records if a P.O. Box is your mailing address

Contact Person Information

Contact's First Name	Last Name

Phone Number	Fax Number	Email

Supervisor Information

Supervisor First Name	Last Name

Phone Number	E-Mail

Employee Information

First Name | Middle Name | Last Name

Social Security Number | Employee ID Number *(if applicable)* | Date of Hire *(mm/dd/yyyy)*

Job Title | Work Phone Number

Job Class
☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Home Phone Number

Work Location Address | City | State | ZIP

Is condition work-related? ☐ Yes ☐ No If yes, provide:

Workers' Comp (WC) Carrier | Workers' Comp Claim Number | W/C Contact Person's Phone Number

W/C Contact Person -
First Name | Last Name

Date Last Worked *(mm/dd/yyyy)* | First Date of Absence *(mm/dd/yyyy)* | Date Returned To Work *(mm/dd/yyyy)* ☐ Actual ☐ Estimated | Eff. Date of Coverage *(mm/dd/yyyy)*

Basic Earnings *(exclusive of overtime, bonus, etc.)*

$ _____ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annual

Premium contributions ☐ Pre-Tax ☐ Post-Tax
Employer ____ % Employee ____ %

Benefit Amount

Payroll Classification
☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly
☐ Union ☐ Non-Union ☐ Other _____

Employee's Status as of First Day of Absence

☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Terminated ☐ Retired

If other than Active, please explain

Hours Worked Per Week ☐ Full Time ☐ Part Time | Work Week ☐ Regular ☐ Variable

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

If STD buy up, date enrollment card signed *(mm/dd/yyyy)*

LTD Coverage? ☐ Yes ☐ No

Has return to work been discussed with employee? ☐ Yes ☐ No

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

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 Date	To Date
Salary Continuance/Sick Leave	☐	☐				
COVID 19 Paid Sick Leave	☐	☐				
Worker's Compensation	☐	☐				
State Disability	☐	☐				
Other *(please identify)*	☐	☐				

Provide weekly deduction amounts, if applicable:

	Pre Tax	Post Tax	$ Weekly Amount
Medical	☐	☐	
Life	☐	☐	
Dental	☐	☐	
LTD	☐	☐	
Other (*please identify*)	☐	☐	

Sign Here Authorizing Employer Signature _____ Date *(mm/dd/yyyy)* _____

SECTION 2: To Be Completed by Employee

Some services in connection with your Disability Claim may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

First Name | Middle Name | Last Name

Social Security Number | Employee ID number *(if applicable)* | Date of Birth *(mm/dd/yyyy)* | Gender ☐ M ☐ F

Address | City | State | ZIP

We require a street address for our records if a P.O. Box is your mailing address | Email

Home Phone Number | Marital Status ☐ Married ☐ Single ☐ Other | Federal Tax Status ☐ Married ☐ Single | Tax Exemptions *(Number)*

Date Disability Began *(mm/dd/yyyy)* | Is your disability due to ☐ Illness? ☐ Injury/Accident? If due to injury/accident, provide | Date *(mm/dd/yyyy)* | Time ☐ 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: From	Dates of Treatment: To	Physician/Provider Specialty

Please describe what prevents you from performing the duties of your job.

Sign Here Employee Signature | Date *(mm/dd/yyyy)*

SECTION 3: To Be Completed by Attending Physician/Provider

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 First Name	Middle Name	Last Name

Date Disability Began *(mm/dd/yyyy)*	Expected Return to Work Date *(mm/dd/yyyy)*	Initial date of treatment for this disability *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

Is this condition work related? ☐ Yes ☐ No

Primary Diagnosis Code	Diagnosis
Secondary Diagnosis Code	Diagnosis

Objective Findings

CPT4	Procedure	Date *(mm/dd/yyyy)*

If pregnancy, delivery date *(mm/dd/yyyy)*	☐ Expected *(mm/dd/yyyy)*	☐ Actual *(mm/dd/yyyy)*	Type of delivery

If patient has been hospitalized ☐ Inpatient ☐ Outpatient	Admitted *(mm/dd/yyyy)*	Discharged *(mm/dd/yyyy)*

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)*

_____

Physician/Provider Specialty		E-mail		
Address		City	State	ZIP
Tax ID Number	Phone Number	Fax Number		
Sign Here Signature of Physician/Provider			Date *(mm/dd/yyyy)*	

SECTION 4: How to Submit This Form

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531

MetLife

Authorization to Disclose Information About Me

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Section 2 requires your signature.
- Return this form as soon as possible to expedite processing of your claim as described in Section 3 and keep a copy for your records.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf and include the claim number at the top of each page.

Your refusal to complete and sign this form may affect your eligibility for Benefits.

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)*.

NOTE TO ALL HEALTH CARE PROVIDERS:

The Genetic Information Nondiscrimination Act of 2008 *(GINA)* prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 1: Claimant Information

First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Claim Number	ID Number *(if applicable)*

SECTION 2: Authorization & Signature

For purposes of determining my eligibility for disability benefits or request for reasonable accommodation under the Americans with Disabilities Act *(ADA)*, the administration of my disability benefit plan *(which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits)*, and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any Workers' Compensation, employee assistance or disease management program, 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/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to Metropolitan Life Insurance Company *("MetLife")*, 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 or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, Workers' Compensation, employee assistance, or disease management programs, 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 any time by writing to MetLife Disability at PO Box 14590, Lexington KY 40512-4590, 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.

Sign Here	Claimant's Signature	Date *(mm/dd/yyyy)*

SECTION 3: How to Submit This Form

Mail:

MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:

1-800-230-9531

Fraud Warnings

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.

Delaware: 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.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Idaho, Indiana and Oklahoma: WARNING: 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.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Texas: 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.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

MetLife

Attending Physician Statement

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Metropolitan Life Insurance Company

Things to Know Before You Begin

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Section 2 **MUST** be completed by your physician.
- Submitting an incomplete form may delay processing your claim.
- Some physicians may charge for completion of this form. Any such charge is your responsibility.
- **New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please write the claim number on any additional documents you send.

SECTION 1: Claim Information (To be completed by the person submitting the claim, or by the physician if received directly.)

Claimant First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Customer Name	Occupation

Physician First Name	Last Name

Physician Phone Number	Claim Number

Authorization For Physician to Share My Medical Information

I authorize my physician to release to MetLife Disability any information collected in the course of examining or treating me as a patient.

Sign Here	Claimant Signature	Date *(mm/dd/yyyy)*

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

SECTION 2: Information About Your Patient's Health (To be completed by the physician providing treatment for the disability condition.)

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- **After you complete this form, please submit it along with office notes and results from any diagnostic testing related to your patient's condition *(e.g., x-ray, lab tests, EKG or MRI)***. See Section 4 below for instructions on how to submit this completed form and any supporting documents to MetLife Disability.

History Of Your Patient's Condition

First date of treatment for this condition *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

What is the cause of your patient's symptoms? *(Check one)*

☐ Injury

☐ Illness

☐ Pregnancy (*Type of birth* - ***Check one below***)

☐ Cesarean ☐ Natural Birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)* _____

List any other physicians or specialists you referred your patient to:

First name	Last name	Specialty	Phone number

Is your patient's condition work-related? ☐ Yes ☐ No

Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Facility Name

Address	City	State	ZIP

About The Diagnosis And Treatment Of Your Patient

Primary Diagnosis Code	Description

Secondary Diagnosis Code	Description

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

List the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you return this form to us)*

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT-4 procedure code	Description	Date *(mm/dd/yyyy)*

List any medications prescribed:

Medication name	Dosage

About Your Patient's Restrictions and Limitations

Your patient's dominant hand *(Check One):* ☐ Right ☐ Left

How many hours in a workday can your patient:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Sit		☐	☐		
Stand		☐	☐		
Walk		☐	☐		
Climb		☐	☐		
Twist/Bend/Stoop		☐	☐		
Reach above shoulder level		☐	☐		
Reach front and side at desk level		☐	☐		
Perform fine finger movements		☐	☐		
Perform eye/hand movements		☐	☐		

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

How many hours in a workday can your patient lift or carry:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

How many hours in a workday can your patient push or pull:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

Can your patient operate a motor vehicle? ☐ Yes ☐ No

Is your patient at maximum medical improvement? ☐ Yes ☐ No

Please make any additional notes.

About Your Patient's Prognosis

Have you advised your patient when they can return to work?

☐ Yes *(Check all that apply)*

☐ To regular occupation. On date *(mm/dd/yyyy)* _____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ To any other occupation. On date *(mm/dd/yyyy)* _____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain)*

List any restrictions to work or activity. *(Please be as specific as possible.)*

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

If we need more information, who's the best person at your office to contact? *(Please provide name and phone number/extension.)*

SECTION 3: Physician's Signature and Information

First Name	Last Name

Address	City	State	ZIP

Degree or Specialty	Office Phone Number	Office Fax Number	Tax ID

Sign Here	Signature of Physician	Date *(mm/dd/yyyy)*

SECTION 4: How to Submit this Form

Please send all of the pages of this form and any supporting documents, adding the claim number to the top of each page, to MetLife Disability by:

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531

Fraud Warnings

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