MetLife

Long Term Disability claim form employer statement

Metropolitan Life Insurance Company

Instructions for completing the claim form

- Complete all applicable areas of the claim form.
- Sign the claim form.
- Fax this claim form to expedite your claim – retain original for your records.

SECTION 1: Employer information

Name of employer *(Must answer)*

Group report number	Subdivision number	Branch number

Address	City	State	ZIP code

Employer Tax ID number

Subsidiary or Division name

Address	City	State	ZIP code

Contact person's - First name	Last name

Phone number	Contact person's email

SECTION 2: Employee information

First name *(Must answer)*	Middle initial	Last name

Date of birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Social Security number *(Must answer)*	Claim number *(If known)*

Address	City	State	ZIP code

Home phone number	Marital status ☐ Married ☐ Single ☐ Other	W4 filing status	Exemptions

Date of hire *(mm/dd/yyyy)*	Current occupation	How long at this occupation?

Employee - First name | Middle initial | Last name

Claim number *(If known)*

Work location address | City | State | ZIP code

Employee ID number | Work phone number

Supervisor - First name | Last name

Phone number | Supervisor email

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 | City | State | ZIP

Contact person's - First name | Last name

Phone number | Worker's compensation claim number

Date last worked - must answer *(mm/dd/yyyy)* | First date of absence *(mm/dd/yyyy)*

Date returned to work *(mm/dd/yyyy)* | ☐ Actual ☐ Estimated | Effective date of coverage *(mm/dd/yyyy)*

Earning on last day worked | Benefit rate | Premium contribution 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

☐ Active ☐ LOA ☐ Terminated ☐ Vacation ☐ Laid off ☐ Retired

If other than active, Please explain

Employee - First name	Middle initial	Last name

Claim number *(If known)*

LTD: Date enrollment card signed *(mm/dd/yyyy)*

If buy up: Date enrollment card signed *(mm/dd/yyyy)*

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 date** *(mm/dd/yyyy)*	**To date** *(mm/dd/yyyy)*
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)*	☐	☐				

SECTION 4: Employee's job description

Employee's job title

Usual days worked _____ /per week

Hours worked _____ /per week

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 Please provide a brief summary of the employee's job to include the product(s) produced or services provided by the employee or a copy of his/her job description.

Employee - First name	Middle initial	Last name

Claim number *(If known)*

Has a formal job analysis been completed? ☐ Yes ☐ No

If yes, you may attach a copy of the job analysis to this form in place of completing these fields.

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	☐	☐	☐	☐	☐
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	☐	☐	☐	☐	☐

Employee - First name	Middle initial	Last name

Claim number *(If known)*

	0	1-2	3-4	5-6	7-8+
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	☐	☐
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	☐	☐

Employee - First name	Middle initial	Last name

Claim number *(If known)*

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.

Name of person completing this section

First name	Last name

Title	Phone number	Email

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

SECTION 5: 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 false or fraudulent information to obtain or amend insurance coverage or to make a 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.

SECTION 6: How to submit this form

Mail:
MetLife Disability
P.O. Box 14590
Lexington, KY 40512-4590

Fax:
1-800-230-9531