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

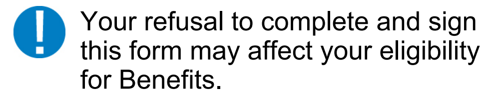
MetLife

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 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 life insurance and civil damages. It is also unlawful for 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 respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Divisions of Insurance with the Department of Regulatory Agencies.

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 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 defraud or deceive any insurance company, files a statement of claim 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 of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it 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.