MetLife

Disability Waiver Benefit Claim Statement

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company

Things to know before you begin

- In the event claim is being filed under the Applicant's Waiver of Premium Benefit, then the information should be furnished with respect to the Applicant.
- In the event claim is being filed under the Disability Waiver of Premium Benefit, then the information should be furnished with respect to the Insured.
- If the Insured/Applicant is not competent, this statement may be completed by their spouse, parent or legal representative. If applicable, submit copies of your Power of Attorney, Guardianship or Conservator appointment documents with this form.

SECTION 1: Information

1. *Select one* ☐ **Insured** ☐ **Applicant**

First name	Middle name	Last name

2. Social Security number
3. Date of birth *(mm/dd/yyyy)*

4. Address | City | State | ZIP

5. Phone number

6. List all policy numbers ______________________

7. Employer | 8. Occupation

9. Employer's address | City | State | ZIP

10. What is the reason for disability? Please provide specific diagnosis or describe your symptoms:

11. Date of disability *(mm/dd/yyyy)*

12. I was unable to work from ____ to ____
Date *(mm/dd/yyyy)* Date *(mm/dd/yyyy)*

13. I worked part time from ____ to ____
Date *(mm/dd/yyyy)* Date *(mm/dd/yyyy)*

14. Check one:
☐ I am presently disabled ☐ I am not presently disabled ☐ Disability ceased on ____
Date *(mm/dd/yyyy)*

15. Your last day worked prior to disability
Date *(mm/dd/yyyy)*

16. I expect to return to work on or about
Date *(mm/dd/yyyy)*

17. Are you receiving disability benefits? ☐ Yes ☐ No

18. Are you covered under a MetLife group insurance plan or disability income policy? ☐ Yes ☐ No
If yes, please indicate below.
Group Company name ______
Group policy number ______ Certificate number ______
DI policy number ______

19. Have you applied for or are you receiving Social Security Disability Income (SSDI) Benefits? ☐ Yes ☐ No

SECTION 2: Physician *(Please provide us with information regarding the physician who can verify your disability):*

20. First name	Middle name	Last name

21. Address	City	State	ZIP

22. Phone number	23. Fax number

24. Dates of Treatment from ______ to ______
Date *(mm/dd/yyyy)* Date *(mm/dd/yyyy)*

Please note if you've been approved for SSDI, we do not accept approval for these benefits alone as proof of disability.

SECTION 3: Fraud warnings

The laws of the states below require the Company to provide the following statements:

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.

Arkansas, Louisiana and Rhode Island: 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.

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.

Delaware, 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.

District of Columbia: WARNING: It is a crime to provide false or misleading information to any insurer person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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

New Mexico: 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 civil fines and criminal penalties.

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Ohio: 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 is guilty of insurance fraud.

Oregon: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Pennsylvania: 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 file, assist or abet 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.

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.

Please note that our decision regarding your eligibility for the waiver benefit is independent of any third party decision.

I have read and understand the Fraud Warning Statements included in the claim package. I hereby certify that the statements given are true and accurate.

SECTION 4: Signature

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

If other than the Insured or Applicant please, print name and provide relationship.

First name	Middle name	Last name

Relationship ____________________

SECTION 5: How to submit this form

Please mail your completed claim to the following address:

Product/Service Request	**Metropolitan Life Insurance Company** **Metropolitan Tower Life Insurance Company**
Disability Waiver **Non-Equity Products**	**Mailing Address** PO Box 310 Warwick, RI 02887-0310 **Fax Number** 1-401-827-3407 **Phone Number** 1-800-638-5000
Disability Waiver **Equity Products**	**Mailing Address** PO Box 353 Warwick, RI 02887-0353 **Fax Number** 1-401-827-3407 **Phone Number** 1-800-638-5000

MetLife

Attending Physician Statement of Disability

Things to know before you begin

- Please fully complete this side of the form. We will use this information to make a decision about your patient's disability claim.
- If your patient was not employed outside of the home or was a student at the time of disability, then that activity should be considered their regular occupation in answering the following questions.

The Company is not responsible for any expense incurred for completion of this statement.

SECTION 1: Patient information

First name	Middle name	Last name

Address	City	State	ZIP

Date of birth *(mm/dd/yyyy)*	List all policy numbers

SECTION 2: History

a. When did symptoms first appear or accident happen? ______

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

c. Date patient ceased work because of disability? ______

d. Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes", please state when and describe ______

e. Name and address of other treating physicians: ______

f. Was your patient ever hospitalized for the same or a similar condition? ☐ Yes ☐ No
If yes, date(s) of hospitalization *(mm/dd/yyyy)* ______
If yes, please provide the name and address of the facility ______

SECTION 3: Diagnosis

a. Primary diagnosis: ______

b. Secondary diagnosis *(including complications)*: ______

c. Prognosis: ______

SECTION 4: Treatment

a. Date of first visit: ______ Date of last visit: ______
Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other *(please specify)* ______

b. When did you last examine the patient? ______

c. Nature of current treatment *(please include all medications, therapies and surgeries)*: ________________

____

SECTION 5: Mental condition

Is the patient competent to endorse checks and direct how the proceeds are used? ☐ Yes ☐ No

If "No", from what date has the patient been declared incompetent? ____________________

SECTION 6: Degree/extent of disability

a. Has the patient been prevented from engaging in his/her occupation due to this illness or injury?

☐ Yes ☐ No

If "Yes", please specify the time periods involved:

Part-time from			Full-time from		
Date *(mm/dd/yyyy)*	to	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	to	Date *(mm/dd/yyyy)*
Date *(mm/dd/yyyy)*	to	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	to	Date *(mm/dd/yyyy)*

b. If question is answered yes, has the sickness or injury also prevented this patient from engaging in any other occupation? ☐ Yes ☐ No

c. Is the patient: Confined to a bed, home or hospital? ☐ Yes ☐ No

If patient is confined, please provide additional details and furnish date(s) of confinement

____

d. Do you expect a significant change in the patient's condition: ☐ Yes ☐ No

e. Please provide any additional information that you feel may be helpful in our evaluation of your patient's claim.

____

____

____

____

____

____

SECTION 7: About your patient's restrictions and limitations

Patient's ability to	Number of hours *(select one)*	Continuously or	Intermittently
Sit	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8	☐	☐
Stand	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8	☐	☐
Walk	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8	☐	☐

Patient's ability to	**Yes**	**No**
Climb	☐	☐
Twist/bend/stoop	☐	☐
Reach above shoulder level	☐	☐
Operate a motor vehicle	☐	☐

Patient's ability to lift/carry	Never	Occasionally	Frequently	Continuously
	0%	1-35%	36-66%	67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐
Over 100 lbs.	☐	☐	☐	☐

Patient's ability to perform repetitively	Right Hand		Left Hand	
	Yes	No	Yes	No
Fine finger movements	☐	☐	☐	☐
Eye/hand movements	☐	☐	☐	☐
Pushing/pulling	☐	☐	☐	☐
Your patient's dominant hand	☐		☐	

In your opinion, why is your patient unable to perform his or her current occupation?

____

Do you expect improvement in any area? ☐ Yes ☐ No

If yes, please comment and give dates/timeframes.

____

In your opinion, how many hours per day can your patient work? ______________

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

Do you suggest that your patient get involved in any of the following activities? ☐ Yes ☐ No

If yes, please check all that apply

☐ Physical Therapy ☐ Occupational Therapy ☐ Cardiac Rehabilitation
☐ Pain Management Program ☐ Work Hardening Program ☐ Job Modification
☐ Vocational Rehabilitation ☐ Psychological Counseling ☐ Other ______________

Did you discuss these options with your patient? ☐ Yes ☐ No

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Please note that our decision regarding your eligibility for the waiver benefit is independent of any third party decision.

SECTION 9: Signature(s)

Physician - First name	Middle name	Last name

Specialty	Phone number *(include area code)*

Address	City or town	State or Province	ZIP

Hospital affiliations *(name and address)*

Additional information

Sign Here	Physician signature	Date *(mm/dd/yyyy)*

SECTION 10: How to submit this form

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Disability Waiver **Non-Equity Products**	**Mailing Address** PO Box 310 Warwick, RI 02887-0310 **Fax Number** 1-401-827-3407 **Phone Number** 1-800-638-5000
Disability Waiver **Equity Products**	**Mailing Address** PO Box 353 Warwick, RI 02887-0353 **Fax Number** 1-401-827-3407 **Phone Number** 1-800-638-5000