MetLife

Health Screening Benefit Claim Form

Please complete this form in its entirety

Metropolitan Life Insurance Company
Attn: Group Benefits
P.O. Box 80826
Lincoln, NE 68501-0826
Toll Free Phone:
1 866 626 3705
Fax Number: 1 855 306 7350
https://mybenefits.metlife.com

Return completed form by fax, mail or on-line at (https://mybenefits.metlife.com).

SECTION 1: Certificateholder Information

Certificateholder - First Name	Middle Name	Last Name

Certificate Number

Street Address	City	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female	Social Security Number

Cell Phone Number	Daytime Phone Number	Evening Phone Number

EMAIL Address *(optional)*	Employer Name

SECTION 2: Patient Information *(if certificateholder is the patient, no need to complete the below)*

First Name	Middle Name	Last Name

Daytime Phone Number	Evening Phone Number	Relationship to Insured

SECTION 3: Medical Information

If a covered person undergoes a covered Health Screening test while such covered person is insured under this Policy, the following information must be provided to Us regarding the covered test performed.

Physician Name

Address	City	State	ZIP Code

Phone Number

Name of Testing Facility *(if different from Physician office)*

Address	City	State	ZIP Code

Phone Number

Date of Health Screening Test *(required) (mm/dd/yyyy)*	Test Type *(required)*

Date of Health Screening Test *(required) (mm/dd/yyyy)*	Test Type *(required)*

SECTION 4: Special Payment Instructions & Direct Deposits

- If you would like claim benefits paid using direct deposit, please provide the information requested for the bank where you have your account.
- The sample check below may help you locate your bank account and bank routing numbers. Please be sure that you are referencing one of your checks, not a deposit or withdrawal slip.
- If a savings account is used, please check with your bank representative for the appropriate routing and account numbers.
- Use the space below if you need to provide any special instructions. *(e.g., requesting that your claim proceeds be sent to an address other than the address of record).*

Would you like claim benefit payments paid using direct deposit?

☐ Yes ☐ No *(If Yes complete the Account Information section below.)*

Bank Name	Bank Telephone Number

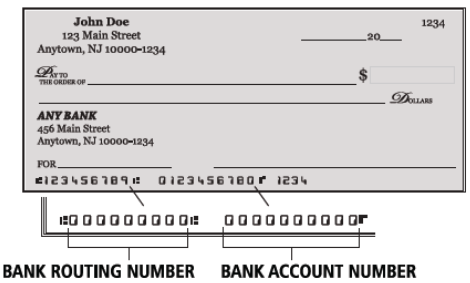
Bank Street Address	City	State	ZIP Code

Type of Account *(check one)*: ☐ Checking ☐ Savings

Be sure to confirm your account and routing numbers with your bank to ensure prompt processing

Bank Account Number

Bank Routing Number



Authorization & Signature

- I request MetLife to send my payments to the financial institution designated in Section 4 for deposit into my account. This agreement will remain in effect until MetLife receives notice from me to the contrary.
- I understand that MetLife will not be liable for any failure to change or terminate this agreement until a written request is received from me in satisfactory form and reasonable time has passed for MetLife to act upon it.
- If any overpayment is credited to my account in error, I authorize and direct my financial institution to debit my account and to refund such overpayment to MetLife.

Name *(Please print)*	Annuitant ID/Certificate Number
Sign Here Signature	Date *(mm/dd/yyyy)*