MetLife®
Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center
P.O. Box 6120
Scranton, PA 18505-9972
Toll Free Phone: 1-800 GET MET 8
Fax Number: 1-866-268-2621

Critical Illness Insurance
Health Screening Benefit Claim Form

Claim Number _____ **(for home office use only)**

SECTION A: Insured/Certificate Holder Information				
Insured/Certificate Holder Name (First, Middle Initial, Last Name)	Gender	Date of Birth	Certificate Number	SSN
		mm/dd/yy		
Address (Street) City State Zip Code			Daytime Phone Number	

SECTION B: Submitter Information (if claim submitted by someone other than the insured)	
Name (First, Middle Initial, Last Name)	Relationship to insured
Daytime Phone Number	Evening Phone Number

INSTRUCTIONS:

If a covered person undergoes a covered Health Screening while such covered person is insured under this Policy, proof of the covered Health Screening must be sent to Us. We must receive proof not later than 12 months after the date of the Health Screening exam. When We receive such proof, We will review the claim and if we approve it, will pay for such covered Health Screening Benefit.

Step 1 - Complete section A & B.

Step 2 - Select the Proof Requirement Method you are using.

Proof Requirement - Select one of the following and attach a copy to your claim form.

☐ Explanation of benefits or Proof of service - Provide a copy of an explanation of benefits or similar proof that the test in section C was completed.

☐ Physician Statement - Complete Section C and Attachment 2.

Step 3 - Review and sign pages 3 and 4 of the claim form.

Step 4 - Mail or fax the completed form and the attachments as instructed in Step 2 & 3.

(☞) This indicates where a signature is required.

SECTION C: What Health Screening Benefit Are You Claiming?	
☐ Breast MRI	☐ Fasting plasma glucose test
☐ Breast ultrasound	☐ Two hour post-load plasma glucose test
☐ Breast sonogram	☐ Hemocult stool specimen
☐ Carotid doppler	☐ Mammogram
☐ Colonoscopy	☐ Pap smears or thin prep pap test
☐ Virtual colonoscopy	☐ Prostate-specific antigen (PSA) test
☐ Flexible sigmoidoscopy	☐ Serum cholesterol test to determine LDL and HDL levels
☐ Endoscopy	☐ Blood test to determine total cholesterol
☐ Digital rectal exam (DRE)	☐ Blood test to determine triglycerides
☐ Electrocardiogram (EKG)	☐ Stress test on bicycle or treadmill
☐ Fasting blood glucose test	

(Continued on Following Page)

Fraud Warning:

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.

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.

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

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 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 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.

Fraud Warning *(continued)*:

Oregon and 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.

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.

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.

Certification and Signature:

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. I have read the applicable Fraud Warning(s) provided in this form. **New York Residents: 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 claim for each such violation.**

Under penalty of perjury, I certify:

1. **That the number shown on this form is my correct taxpayer identification number; and**
2. **That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and**
3. **I am a U.S. citizen, or a U.S. resident for tax purposes.**

Please note: If item 2 or 3 above is not true, cross out the applicable item(s). The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Name of Claimant (Please Print):	**Social Security Number:**
Signature of Claimant or Authorized Representative:	**Date:** mm/dd/yy

MetLife®

Authorization to Disclose Health Information

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center
P.O. Box 6120
Scranton, PA 18505-9972
Toll Free Phone: 1 800 GET-MET 8
Fax Number: 1-866-268-2621

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).

Instructions for completing the form:

1. **Complete all applicable areas of the form.**
2. **If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.**
3. **Sign this form.**
4. **Fax or return this form as soon as possible to expedite processing of your claim - retain original for your records.**

Your refusal to complete and sign this form may affect your eligibility for benefits under your critical illness insurance policy.

	mm/dd/yy
Name of Claimant or Authorized Representative (Please Print)	**Date of Birth**

For purposes of determining my eligibility for critical illness benefits, the administration of my critical illness benefit plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for critical illness benefits, 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/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its critical illness benefit plan, 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 critical illness claim.
2. **I permit** MetLife and my employer (if applicable) to disclose in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and critical illness 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 Critical Illness at **P.O. Box 6120, Scranton, PA 18505-9972**, 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.

	mm/dd/yy
Signature of Claimant or Authorized Representative	**Date**

If signed by Authorized Representative, describe your authority (e.g., guardian, conservator, power of attorney, etc.) and provide documentation.

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Health Screening Benefit Physician Statement

Claim Number _____ (for home office use only)

Physician Statement

☞ **Please sign the Authorization to Disclose Health Information and submit it with this form to your Physician.**

I authorize the release of any medical information necessary to process this claim. The signature of the insured or authorized representative of the insured is required below.

(☞) _____ mm/dd/yy

Signed **Date**

_____

Relationship to Insured

SECTION D: Please ask your Physician to complete this section

Patient's Name (First, Middle Initial, Last Name)	Patient's Gender	Patient's Date of Birth
		mm/dd/yy

Address (Street)	City	State	Zip Code	Phone Number

Check off the test(s) with which your patient has completed:

- ☐ Breast MRI
- ☐ Breast ultrasound
- ☐ Breast sonogram
- ☐ Carotid doppler
- ☐ Colonoscopy
- ☐ Virtual colonoscopy
- ☐ Flexible sigmoidoscopy
- ☐ Endoscopy
- ☐ Digital rectal exam (DRE)
- ☐ Electrocardiogram (EKG)
- ☐ Fasting blood glucose test
- ☐ Fasting plasma glucose test
- ☐ Two hour post-load plasma glucose test
- ☐ Hemocult stool specimen
- ☐ Mammogram
- ☐ Pap smears or thin prep pap test
- ☐ Prostate-specific antigen (PSA) test
- ☐ Serum cholesterol test to determine LDL and HDL levels
- ☐ Blood test to determine total cholesterol
- ☐ Blood test to determine triglycerides
- ☐ Stress test on bicycle or treadmill

Please provide the following information:

	TEST	Completion Date
Date the Health Screening tests were completed		mm / dd / yy
		mm / dd / yy
		mm / dd / yy
		mm / dd / yy

As the Physician for the above-named patient, by my signature below, I attest that the Health Screening tests have been completed on the dated provided by me.

_____ _____

Please Print Your Name **Phone Number**

_____ _____ mm/dd/yy

Signed **Medical Specialty** **Date**

_____

Address