MetLife

Critical Illness Insurance Claim Form

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
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

Things to know before you begin

- If you are submitting a claim for a Critical Illness which you have not yet reported to us, please complete this claim form. Once we receive a completed claim form we consider this Critical Illness to have been reported to us. Return completed form by fax, mail or on-line at (https://mybenefits.metlife.com).
- Anytime you are submitting a claim to us, please provide us with supporting documents from the provider related to the Critical Illness for which a claim is being made. The supporting documents must include: 1) the diagnosis; 2) pathology reports, surgical notes, lab results, or clinical records that support the diagnosis of the covered condition and 3) the date(s) of diagnosis.

Please complete Sections 1 through 4. Review, sign and date pages 4 and 5. Complete Section 7 on the Physician's Attachment. Your physician must complete the remainder of the Physician's Attachment (all of Section 8) and return the completed form.

Supply information about the certificateholder.

SECTION 1 - Certificateholder Information

Certificateholder Name *(First, Middle Initial, Last Name)* | Certificate Number

Address - Street

City | State | Zip Code

Date of Birth *(Month/Day/Year)* | Gender ☐ Male ☐ Female | Social Security Number

Cell Phone Number | Daytime Phone Number | Evening Phone Number

EMAIL Address *(optional)* | Employer Name

Supply information about the patient.

SECTION 2 - Patient Information

☐ Same as Section 1 *(If you check this box, you do not need to complete this section. You may skip to Section 3.)*
☐ Spouse ☐ Child

Patient Name *(First, Middle Initial, Last Name)*

Home Address - Street

City | State | Zip Code

Date of Birth *(Month/Day/Year)* | Gender ☐ Male ☐ Female | Social Security Number

Cell Phone Number	Daytime Phone Number	Evening Phone Number

SECTION 3 - What Type of Condition Are You Claiming?

- Refer to your group certificate or Summary Plan Description for a complete description of these benefits.
- Not all plans include these benefits.

Please check off the condition that applies to your claim:

☐ Cancer
☐ Coronary Artery Bypass Graft
☐ Heart Attack
☐ Stroke
☐ Alzheimer's Disease
☐ Kidney Failure
☐ Major Organ Transplant

If the claimant is deceased, check here ☐ and provide a copy of the death certificate.

Listed Conditions *(check the Listed Condition(s) being claimed)*:

☐ Addison's disease *(adrenal hypofunction)*
☐ Amyotrophic lateral sclerosis *(Lou Gehrig's disease)*
☐ Cerebral palsy
☐ Cerebrospinal meningitis *(bacterial)*
☐ Cystic fibrosis
☐ Diphtheria
☐ Encephalitis
☐ Huntington's disease *(Huntington's chorea)*
☐ Legionnaire's disease
☐ Malaria
☐ Multiple sclerosis *(definitive diagnosis)*
☐ Muscular dystrophy
☐ Myasthenia gravis
☐ Necrotizing fasciitis
☐ Osteomyelitis
☐ Poliomyelitis
☐ Rabies
☐ Sickle cell anemia *(excluding sickle cell trait)*
☐ Systemic lupus erythematosus *(SLE)*
☐ Systemic sclerosis *(scleroderma)*
☐ Tetanus
☐ Tuberculosis

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

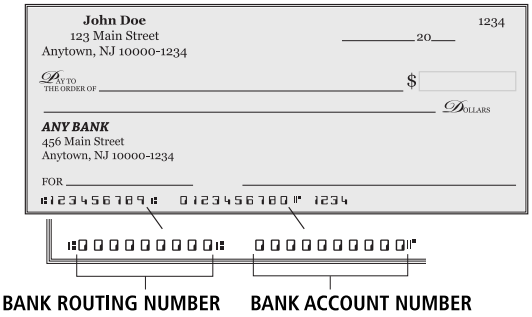
Be sure to confirm your account and routing numbers with your bank to ensure prompt processing.

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.

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.

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.

SECTION 6 - Certification & Signature

By signing below, I acknowledge:

- All information I have given is true and complete to the best of my knowledge and belief.
- 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 / social security 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/yyyy)*

If signed by Authorized Representative, describe your authority and provide documentation.

(e.g., guardian, conservator, power of attorney, etc.)

MetLife

Authorization to Disclose Health Information

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Product
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

Things to know before you begin

- **Instructions for completing the form: complete all applicable areas of the form; sign this form; fax or return this form as soon as possible to expedite processing of your claim - retain original 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.**

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

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).

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 80826, Lincoln, NE 68501-0826, 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.

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

If signed by Authorized Representative, describe your authority and provide documentation.

(e.g., guardian, conservator, power of attorney, etc.)

MetLife

Critical Illness Insurance Claim - Physician Statement

Things to know before you begin

- The patient submitting this Critical Illness Claim must complete Section 7 before giving it to a physician.
- Any fee charged by the physician for completing this form is the patient's responsibility.
- The physician must sign section 8E after completing the claim form.
- The physician must return the completed claim form and any attachments by fax or by mail to the address listed in the header of the claim form or directly to the patient.
- If you have questions, please call 1 866 626 3705.

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You must sign Section 7 below. Your Physician/Provider must complete Section 8.

SECTION 7 - Patient Authorization & Signature

I authorize the release of any medical information necessary to process this claim.

Signed | **Date** *(mm/dd/yyyy)*

Relationship to Insured

SECTION 8 - Information Needed From Your Physician/Provider

8A - Patient Information

First Name | Middle Name | Last Name

Street Address

City | State | ZIP Code

Date of Birth *(mm/dd/yyyy)* | Gender | Daytime Phone Number

8B - Condition Information

Check off the condition with which your patient was diagnosed / treated for:

☐ Cancer
☐ Coronary Artery Bypass Graft
☐ Heart Attack
☐ Stroke
☐ Alzheimer's Disease
☐ Kidney Failure
☐ Major Organ Transplant

If the claimant is deceased, check here ☐

Listed Conditions *(check the Listed Condition(s) being claimed)*:

☐ Addison's disease *(adrenal hypofunction)*
☐ Amyotrophic lateral sclerosis *(Lou Gehrig's disease)*
☐ Cerebral palsy
☐ Cerebrospinal meningitis *(bacterial)*
☐ Cystic fibrosis
☐ Diphtheria
☐ Encephalitis
☐ Huntington's disease *(Huntington's chorea)*
☐ Legionnaire's disease
☐ Malaria
☐ Multiple sclerosis *(definitive diagnosis)*
☐ Muscular dystrophy
☐ Myasthenia gravis
☐ Necrotizing fasciitis
☐ Osteomyelitis
☐ Poliomyelitis
☐ Rabies
☐ Sickle cell anemia *(excluding sickle cell trait)*
☐ Systemic lupus erythematosus *(SLE)*
☐ Systemic sclerosis *(scleroderma)*
☐ Tetanus
☐ Tuberculosis

Date of Illness *(mm/dd/yyyy)* *(First Symptom/Diagnosis Date)*	Date your patient first consulted you for this condition *(mm/dd/yyyy)*

Has the patient previously had the same or similar condition? ☐ Yes ☐ No If "yes," indicate first treatment dates.

8C - Referring and Other Treating Physicians

First Name	Middle Name	Last Name
Street Address		Phone Number
City	State	ZIP Code

First Name	Middle Name	Last Name
Street Address		Phone Number
City	State	ZIP Code

For services related to hospitalization, give hospitalization dates.

Date Confined *(mm/dd/yyyy)*	Through *(mm/dd/yyyy)*	Hospital Name
Street Address		
City	State	ZIP Code

Date Confined *(mm/dd/yyyy)*	Through *(mm/dd/yyyy)*	Hospital Name
Street Address		
City	State	ZIP Code

8D - Please provide the relevant medical documentation as noted below.

History and Medical Documentation needed based on condition checked:

- Full Benefit Cancer – Pathology Reports, surgical reports and TNM Stage_____
- Partial Benefit Cancer – Pathology Reports, surgical reports and TNM Stage _____
- Coronary Artery Bypass Surgery – Open heart surgical reports
- End Stage Kidney Failure – Kidney Specialist records or dialysis records
- Heart Attack – All of the following: Hospital Summary, EKGs, Cardiac Enzymes. If completed, provide any of the following: Thallium Scans, Muga Scans, Stress echocardiogram, Cardiac Catheterization Report
- Bone Marrow, Heart or Major Organ Transplant – Surgical Report and Clinical Records
- Stroke – Documented Neurological deficits, Neuroimaging studies, Clinical Records and Documentation of deficits 30 days post event.
- Listed Conditions - Specialist records, Lab results, Records showing observation of signs, symptoms and tests that led to the Diagnosis of the Listed condition.

8E - Medical Provider Signature and Medical Specialty

Please Print Your Name	Phone Number
Signed	Date *(mm/dd/yyyy)*
Street Address	Medical Specialty
City	State / ZIP Code