PART 1

Group Accident Insurance Claim Form

MetLife

Things to know before you begin

- If you are submitting a claim for an accident which you have not yet reported to us, please complete this claim form. Once we receive a completed claim form for an accident, we consider the accident to have been reported to us.
- If you are submitting a claim for an accident which you have already reported to us (you have already submitted a completed claim form to us), an additional claim form is not required. Include the claim number assigned to the accident at the top of all documentation that you are submitting to us in support of a claim that has previously been reported. Fax, mail or upload any additional documentation related to a claim to the address/fax number located in the top right corner of this form.
- Anytime you are submitting a claim to us, please provide us with supporting documents from the provider related to the injuries and services received for which a claim is being made. The supporting documents must include: 1) the diagnosis; 2) the specific procedure or treatment received; and 3) the date of service.
- If you were treated at an emergency room, attach a copy of the discharge papers from the hospital.
- If you were admitted to a hospital and if your coverage includes benefits for hospitalization, attach documentation (such as an admission and discharge summary) from the hospital showing the number of days hospitalized.

Metropolitan Life Insurance Company
Attn: Group Accident 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

Please complete Part 1 sections A through D. Review, sign and date pages 5 and 6. Return completed form by fax, mail or on-line at (https://mybenefits.metlife.com)

Complete Section 1 on the Physician's attachment. Your physician must complete the remainder of the Physician's attachment (sections 2 through 8) and return the completed form by fax or mail.

Supply information about the certificateholder.

SECTION A: Certificateholder Information

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

Address - Street

City	State	Zip Code

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

Cell Phone Number	Daytime Phone Number	Evening Phone Number

EMAIL Address *(optional)*	Employer Name

Supply information about the patient.

SECTION B: Patient Information

☐ Same as Section A *(If you check this box, you do not need to complete this section. You may skip to Section C.)*

☐ Spouse ☐ Child

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

Home Address - Street

City	State	Zip Code

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

Cell Phone Number	Daytime Phone Number	Evening Phone Number

Describe your accident.

SECTION C: Accident Details

Please provide a complete description of your accident. If the accident required a police report to be filed, attach a copy of the police or accident report. If you were injured in an on-job or occupational injury, attach a copy of the first report of injury filed with your employer.

Date of accident *(Month/Day/Year)*	Location of the accident - City	State

Describe how the accident happened *(Include additional information on a separate sheet of paper if needed.)*

Was the patient the driver in a motor vehicle accident? ☐ Yes *(Attach the police report.)* ☐ No

Was the patient involved in any other type of accident that required a police report? ☐ Yes *(Attach the police report.)* ☐ No

Was the patient at work when the injury occurred? ☐ Yes *(Attach a copy of report of the injury filed with your employer.)* ☐ No

SECTION D: Checklist

Did you complete Section A, Section B and Section C? ☐ Yes ☐ No *(If No, please explain.)*

Did the patient require Ground Ambulance? ☐ Yes ☐ No *(If Yes, provide the date ground ambulance transportation occurred.)*

(Ground Ambulance means a licensed professional ambulance service was required to transport a covered person by ground to or from a hospital or between medical facilities where treatment for an injury is received.)

(Month/Day/Year)

Did the patient require Air Ambulance? ☐ Yes ☐ No *(If Yes, provide the date air ambulance transportation occurred.)*

(Air Ambulance means a licensed professional air ambulance service was required to transport a covered person by air to or from a hospital or between medical facilities where treatment for an injury is received.)

(Month/Day/Year)

Does the patient's companion meet the Lodging Benefit requirements? ☐ Yes ☐ No *(If Yes, provide the date ground ambulance transportation occurred.)*

(Lodging Benefit means the patient is confined in a Hospital for treatment of an Injury and a companion who accompanies the patient while the patient is confined stays in lodging for which a charge is made. Proof that the companion incurred an expense for staying in lodging should be submitted)

(Month/Day/Year)

SECTION E: 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

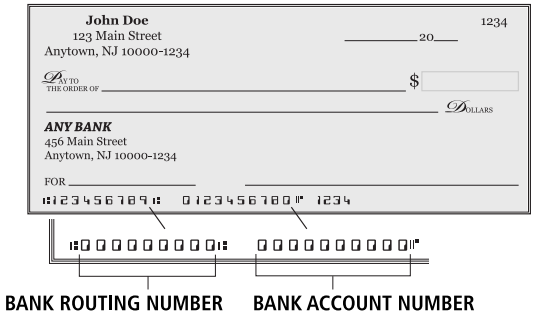
City	State	Zip Code

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 E 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
Signature	**Date** *(mm/dd/yyyy)*

Next Steps:
- Review and complete the Fraud Warnings, Certification & Signature sections.
- Review and complete the Authorization to Disclose Health Information Page.
- Provide the Physician's Attachment and completed Authorization to Disclose Health Information Page to your treating Physician for completion.

Read the following fraud warnings and sign the certification on the next page.

Fraud Warnings, Certification & Signature

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.

Fraud Warnings *(continued)*

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.

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/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.

Signature of Insured or Authorized Representative | Date *(Month/Day/Year)*

Name of Insured or Authorized Representative, if applicable *(First Name, Middle Initial, Last Name) (Please Print)*

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

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

Authorization to Disclose Health Information

MetLife

Things to know before you begin

- **Instructions for completing the form: complete all applicable areas of the form; sign this form; provide a copy along with the Physician's Attachment to your physician.**
- **If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.**

Metropolitan Life Insurance Company
Attn: Group Accident Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826
Toll Free Phone: 1 866 626 3705
Fax Number: 1 855 306 7350

Your refusal to complete and sign this form may affect your eligibility for benefits under your accident 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 accident benefits, the administration of my accident benefit plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for accident 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 accident 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 accident 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 accident claim.

This Authorization to Disclose Health Information 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 Group Accident 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 Patient or Authorized Representative *(Please Print) (First, MI, Last)*

Date of Birth *(Month/Day/Year)*

Signature of Patient or Authorized Representative

Date *(Month/Day/Year)*

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

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

Physician's Attachment

Group Accident Claim – Physician Statement

MetLife

Things to know before you begin

- The patient submitting this Group Accident Claim must complete Section 1 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 page 6 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.

Metropolitan Life Insurance Company
Attn: Group Accident 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

Patient: please complete Section 1.
Physician: you must complete the rest of the Physician's Attachment.
Return completed form by fax, mail or on-line at (https://mybenefits.metlife.com)

The patient must complete this section.

SECTION 1: About the Patient

Patient name *(First, Middle Initial, Last Name)* | Patient birth date *(Month/Day/Year)*

Employer Name your coverage is with

Physician name *(First, Middle Initial, Last Name)* | Physician phone

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

Patient signature | Date *(Month/Day/Year)*

Authorized Representative *(e.g., guardian, conservator, power of attorney, etc.)* | Date *(Month/Day/Year)*

The physician must complete the rest of the Physician's Attachment.

SECTION 2: Listed Benefits

What type of Injury(ies) did your patient sustain as a result of the accident reported in this claim form?
(Please provide details on the page noted next to the injury, otherwise details can be provided on the bottom of this page. If additional space is needed, attach a separate sheet.)

- ☐ Broken Tooth
- ☐ Burn *(Provide details on page 3)*
- ☐ Coma
- ☐ Concussion
- ☐ Dislocation with closed reduction *(other than fingers or toes)*
- ☐ Dislocation with open reduction *(other than fingers or toes)*
- ☐ Dismemberment/Functional Loss *(Provide details on page 5)*
- ☐ Elbow, Hip, Knee or Shoulder Replacement
- ☐ Eye Injury
- ☐ Fracture *(Broken Bone - Provide details on page 3)*
- ☐ Laceration *(Provide details on page 3)*
- ☐ Paralysis *(Provide details on page 4)*
- ☐ Ruptured Disc with Surgical Repair
- ☐ Skin Graft
- ☐ Torn Cartilage in Knee with surgical repair
- ☐ Torn Cartilage in Knee without repair *(exploratory surgery)*
- ☐ Torn or Severed Tendon/Ligament/Rotator Cuff *(with surgical repair)*
- ☐ Torn or Severed Tendon/Ligament/Rotator Cuff *(exploratory surgery)*

What type of service did your patient receive as a result of the accident?

- ☐ Blood/Plasma/Platelets Blood Transfusion
- ☐ Medical Appliance
- ☐ Medical Testing
- ☐ Pain Management *(Only if an Epidural Anesthesia was used as treatment for an injury)*
- ☐ Physician Follow-Up Visit
- ☐ Prosthetic Device
- ☐ Surgery *(Inpatient)*
- ☐ Surgery *(Outpatient Ambulatory)*
- ☐ Therapy Services

Please provide the following documentation.

1. Please provide details that apply to your patient's claim *(complete all that apply)*:

Date of Service	Diagnosis Description	Procedure Code	Procedure Description

2. Has the patient ever had the same or similar condition or injury? ☐ Yes ☐ No *(If "YES," state when and describe.)*

3. Describe any other disease or infirmity affecting the patient's present condition and injury(ies).

4. Give dates of treatment, and nature of treatment other than surgical.

5. Name of Facility/Hospital where treatment was provided.

SECTION 3: Burn *(Percentage of total surface skin area that is affected by the burn)* Check the Box that applies.

2nd Degree Burn: ☐ Less than 10% ☐ At least 10% but less than 25% ☐ At least 25% but less than 35% ☐ 35% or more

3rd Degree Burn: ☐ Less than 10% ☐ At least 10% but less than 25% ☐ At least 25% but less than 35% ☐ 35% or more

Was a skin graft performed as a result of the burns? ☐ Yes ☐ No

SECTION 4: Fracture

Nature of Surgical Procedure, if any. *(Describe fully and give approach used even if more than one is used.)*

Location/Description

Approach Used *(Closed Reduction, Open Reduction, Metal Fixation, Other)* | Date *(Month/Day/Year)*

Location/Description

Approach Used *(Closed Reduction, Open Reduction, Metal Fixation, Other)* | Date *(Month/Day/Year)*

Location/Description

Approach Used *(Closed Reduction, Open Reduction, Metal Fixation, Other)* | Date *(Month/Day/Year)*

SECTION 5: Laceration

If the injury resulted in a Laceration, provide details and method of repair:

☐ Laceration was repaired without stitches

☐ Laceration was repaired with stitches, sutures or staples:

- ☐ Total of all lacerations repaired is less than two inches *(5.08 cm)* long
- ☐ Total of all lacerations repaired is two to six inches *(5.08 to 15.24 cm)* long
- ☐ Total of all lacerations repaired is over six inches *(over 15.24 cm)* long

SECTION 6: Confinement

Was the patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No

Admission Date *(Month/Day/Year)* | Discharge Date *(Month/Day/Year)*

Hospital Name

City | State

SECTION 7: Accidental Dismemberment, Accidental Functional Loss & Paralysis

Functional losses:

- Loss of hearing: permanent deafness in at least one ear, such that it cannot be corrected to any functional degree by any procedure, aid or device.
- Loss of sight: permanent loss of sight in an eye. With correction, visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
- Loss of ability to speak: total and permanent loss of audible communication, if such loss cannot be corrected to any functional degree by any procedure, aid or device.

Paralysis:

- a permanent total and irrecoverable loss of movement of two or more limbs.

Please select the condition your patient has and provide details at the bottom of the page:

☐ Loss of hearing

☐ Loss of sight

☐ Loss of ability to speak

☐ Paralysis

☐ Dismemberment

1. For a dismemberment, which limb/digit was severed or amputated?

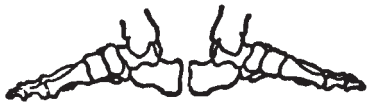
2. For a functional loss or paralysis please describe where the loss has occurred.

3. State the dates on which the severance or amputation, functional loss or paralysis occurred.

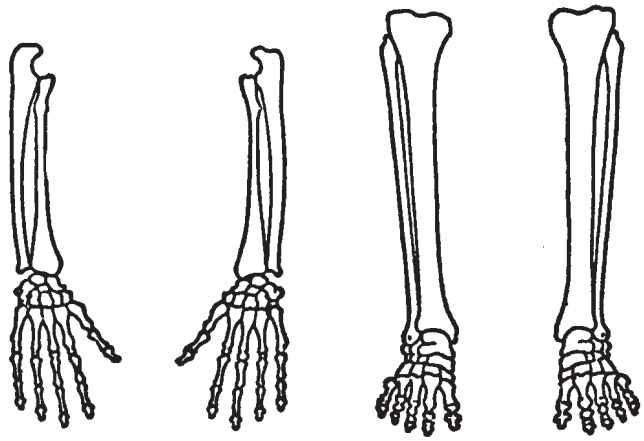
4. State the cause of the severance/amputation/functional loss/paralysis.

5. If a limb/digit was reattached, indicate date of reattachment and functional outcome.

RIGHT LEFT



RIGHT LEFT RIGHT LEFT



State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

The Physician must complete all of Section 8.

SECTION 8: Treatment History

Supporting documents related to the treatment of your patient's injury(ies) resulting from the accident reported to us in this claim form should include:

- the diagnosis
- the specific procedure or treatment the patient received
- the date of service
- surgical reports (where applicable)
- radiology / imaging or similar reports that summarize the nature of the injury in question
- notes and summaries that outline any or all of the following based on the nature of the injury: follow up treatment, rehabilitation or need of a medical appliance or device
- emergency room or hospital discharge summaries related to the injury

1. Date of accident resulting in injury(ies) for which you were consulted. *(Month/Day/Year)*

2. The date(s) your patient first consulted you for injury(ies) resulting from the accident.

3. Date of last treatment for the injury(ies) *(Month/Day/Year)*

4. Describe the exact nature, location, and extent of all injuries sustained.
(If additional space is needed, attach a separate sheet.)

5. Was the accident reported in the claim form the sole cause of the injury(ies) sustained? ☐ Yes ☐ No
(If not, give the particular of any contributing cause or causes.)

6. In your opinion, was the injury caused in any way by illness? ☐ Yes ☐ No
(If yes, what was the date you provided treatment for the illness?)
(Month/Day/Year)

7. Did the patient ever consult you before? ☐ Yes ☐ No
(If yes, please state the dates and the ailments for which you attended.)

Signature of Physician		Date signed *(Month/Day/Year)*	
Name of facility		Phone Number	
Address - Street	City	State	Zip Code