MetLife

Information needed from you and your physician

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Instructions:

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Submitting an incomplete form may delay processing your claim.
- Please make sure to write your name and claim number at the top of pages 2 to 4. If the pages get separated, this will help to ensure timely processing.
- Some physicians may charge for completion of this form. Any such charge would be your responsibility.
- If you live or work in 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Section 1 can be completed by either you or your physician. Section 2 **MUST** be completed by your physician.

To be completed by the person submitting the claim, or by the physician if received directly.

SECTION 1 - About you

Employee - First name	Middle name	Last name

Employee birth date *(mm/dd/yyyy)*	Employer name	Occupation

Physician - First name	Middle name	Last name

Physician phone number	Claim number

Authorize your physician to share your medical information with us

I authorize my physician to release any information collected in the course of examining or treating me as a patient.

Employee signature	Date signed *(mm/dd/yyyy)*

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

To be completed by the physician providing treatment for the disability condition.

SECTION 2 - Information about your patient's health

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- **After you complete this form, you can fax it along with office notes and results from any diagnostic testing related to your patient's condition (e.g., x-ray, lab tests, EKG or MRI) to 800-230-9531.**

History of your patient's condition

First date of treatment for this condition *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

What is the cause of your patient's symptoms? (*Check one.)*

☐ Injury ☐ Illness ☐ Pregnancy - Type of birth: *(Check one.)*

☐ Caesarean ☐ Natural birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)*

List any other physicians or specialists you referred your patient to:

First name	Middle name	Last name	Specialty	Phone

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

Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)*_____ ☐ No

Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)*_____ ☐ No

Facility name	Street address		
City		State	ZIP code

About the diagnosis and treatment of your patient

Primary diagnosis code	Description
Secondary diagnosis code	Description

List the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you fax this form to us.)*

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT–4 procedure code	Description	Date *(mm/dd/yyyy)*

List any medications prescribed.

Medication name	Dosage

About your patient's restrictions and limitations

Your patient's dominant hand: *(Check one.)* ☐ Right ☐ Left

How many hours in a workday can your patient:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Sit		☐	☐		
Stand		☐	☐		
Walk		☐	☐		
Climb		☐	☐		
Twist/Bend/Stoop		☐	☐		
Reach above shoulder level		☐	☐		
Reach front and side at desk level		☐	☐		
Perform fine finger movements		☐	☐		
Perform eye/hand movements		☐	☐		

How many hours in a workday can your patient lift or carry:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

How many hours in a workday can your patient push or pull:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

Can your patient operate a motor vehicle? ☐ Yes ☐ No

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

REQUIRED information in case pages get separated:

First name	Middle name	Last name	Claim number

Please make any additional notes.

About your patient's prognosis

Have you advised your patient about when they can return to work?

☐ Yes *(Check all that apply.)*

- ☐ To regular occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty
- ☐ To any other occupation. On date *(mm/dd/yyyy)*_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain.)*

List any restrictions to work or activity. *(Please be as specific as possible.)*

If we need more information, who's the best person at your office to contact?

SECTION 3 - Physician's signature and information

Signature		Date signed *(mm/dd/yyyy)*	
First name	Middle name	Last name	
Street address		Degree or specialty	
City		State	ZIP code
Office phone number	Fax number	Tax ID	

SECTION 4 - How to submit this form

Please send the first four pages of this form and any supporting documents to MetLife Group Disability by:

Mail:
Metropolitan Life Insurance Company
PO Box 14590
Lexington, KY 40512-4590

Fax:
1-800-230-9531

Please write your patient's claim number on any documents you send.

We're here to help

Please don't hesitate to contact us if you have any questions.

Physician: You can reach us at 1-866-463-6377, Monday through Friday, 8:00 a.m. to 11:00 p.m. Eastern time.

SECTION 5 - Insurance fraud warnings

Before signing this form, please read the warning for the state where you reside or work and, if you are submitting a claim for disability income benefits, 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 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 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 the 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: Any 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 the 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: A person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 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 a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning a fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.