

Indicate type of claim

A&S/STD/Salary Continuance LTD

**Disability Claim
Employer Statement**

MetLife[®]
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

Instructions for completing the claim form:

1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this form to expedite your claim - retain original for your records.

Section 1: Employer Information

Name of Employer - MUST ANSWER		Group Report #	Sub-Division #	Branch #
Address	City	State	Zip Code	Employer Tax ID #
Subsidiary or Division Name		Address		
Contact Person's Name			Phone # () -	

Section 2: Employee Information

Name (Last, First, MI) - MUST ANSWER		Social Security # - MUST ANSWER		Date of Birth (MM/DD/YY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	Zip Code	Home Phone # () -	
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	W 4 Filing Status Exemptions	Date of Hire	Current Occupation	How long at this occupation?	
Work Location Address				Work Phone # () -	
Supervisor Name				Phone # () -	

Section 3: Claim Information

Is claim due to <input type="checkbox"/> Injury? <input type="checkbox"/> Illness? <input type="checkbox"/> Pregnancy?	Description of illness or injury (including date of accident):
Is condition work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide name and address of Workers' Compensation Carrier.	
Name _____	Address _____
Phone # () -	Worker's Comp. Claim # _____

Date Last Worked - MUST ANSWER	First Date of Absence	Date Returned To Work <input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate
Premium contributions Employer _____% Employee _____%	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax	Basic Earnings (exclusive of overtime, bonus, etc.) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Average Hours Worked Per Week	
Employee's Status As Of First Day Absent If other than Active, please explain	<input type="checkbox"/> Active <input type="checkbox"/> LOA <input type="checkbox"/> Terminated	<input type="checkbox"/> Vacation <input type="checkbox"/> Laid Off <input type="checkbox"/> Retired	LTD Only: Date Enrollment Card Signed	If buy up: Date Enrollment Card Signed	
LTD Only: Has employee had previous absences from work due to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates and medical conditions.					
Can employee's job be modified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe how.				Has return to work been discussed with employee? <input type="checkbox"/> Yes <input type="checkbox"/> No	

To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the following sources:

	Applied for	Receiving	\$ Amount	Frequency	From/To Dates
Salary Continuance/Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Short Term Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Workers' Compensation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
State Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Dependent Social Security	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
No Fault (Income Replacement)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Retirement/Pension	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Permanent Total Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Other (Please identify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____



Section 4: Employee's Job Description

Name of Employee: _____ **Usual Days Worked** ___ / per week
Employee's Job Title: _____ **Hours Worked** ___ /per week
Social Security Number: _____ - _____ - _____ **Claim Number:** _____

This section should be completed by someone who is familiar with the employee's job functions (e.g., manager or supervisor). Complete all sections. This section must be completed AND you must also attach a copy of your company's job description for the employee.

Name of Person Completing This Section: _____ **Title:** _____
Signature _____ **Date:** _____

Place an X in each of the appropriate boxes to describe the extent of the specific activity performed by this employee.

	Number of hours Per Work Shift						Number Of Hours Per Work Shift				
	0	1-2	3-4	5-6	7-8+		0	1-2	3-4	5-6	7-8+
1. Sitting						14. Grasping					
2. Standing						A. Simple/Light					
3. Walking						1. Right Hand Only					
4. Bending Over						2. Left Hand Only					
5. Twisting						3. Both Hands					
6. Climbing						B. Firm/Strong					
7. Reaching Above Shoulder Level						1. Right Hand Only					
8. Crouching/Stooping						2. Left Hand Only					
9. Kneeling						3. Both Hands					
10. Balancing						15. Fine Finger Dexterity					
11. Pushing or Pulling						A. Right Hand Only					
12. Repetitive Use of Foot Control						B. Left Hand Only					
A. Right Foot Only						C. Both Hands					
B. Left Foot Only						16. Use of Head and Neck in:					
C. Both Feet						A. Static Position					
13. Repetitive Use of Hands						B. Twisting					
A. Right Hand Only						C. Looking Up					
B. Left Hand Only						D. Looking Down					
C. Both Hands											

	Never 0% Of Time	Occasionally 1-33% Of Time	Frequently 34-66% Of Time	Continually 67-100% Of Time
17. Lifting or carrying				
A. Up to 10 lbs				
B. 11 - 20 lbs				
C. 21 - 50 lbs				
D. 51 - 100 lbs				
E. 100 + lbs				
18. Frequency of Interpersonal Relationships Necessary to Perform the Job				
19. Frequency of Stressful Situations Necessary to Perform the Job				

In the course of performing the job, the employee is required to:

	Yes	No		Yes	No
20. Drive cars, trucks, forklifts and/or other equipment			23. Be exposed to dust, gas, or fumes		
21. Be around moving equipment and/or machinery			If yes; are respirators required		
22. Walk on uneven ground			24. Be exposed to marked changes in temperature or humidity		
			25. Is overtime required on a routine basis		



Disability Claim Employer Statement (Continued)

Name of Employee: _____ Social Security Number: _____ - -

Fraud Warning:

If you are insured under a policy issued in one of the following states, or if you reside in one of the following states, one of the following state warnings may apply to you:

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to \$5,000 plus the value of the claim.

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

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: 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.

Oregon: 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 any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

If you are covered under a self-funded plan or insured under a policy issued in any state other than those listed above, or if you reside in any state other than those listed above, then the following warning may apply to you:

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 any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employer's Authorized Representative

Name _____ Title _____ Phone # _____

Signature _____ Date _____

