Disability Paper Claim Form Guide

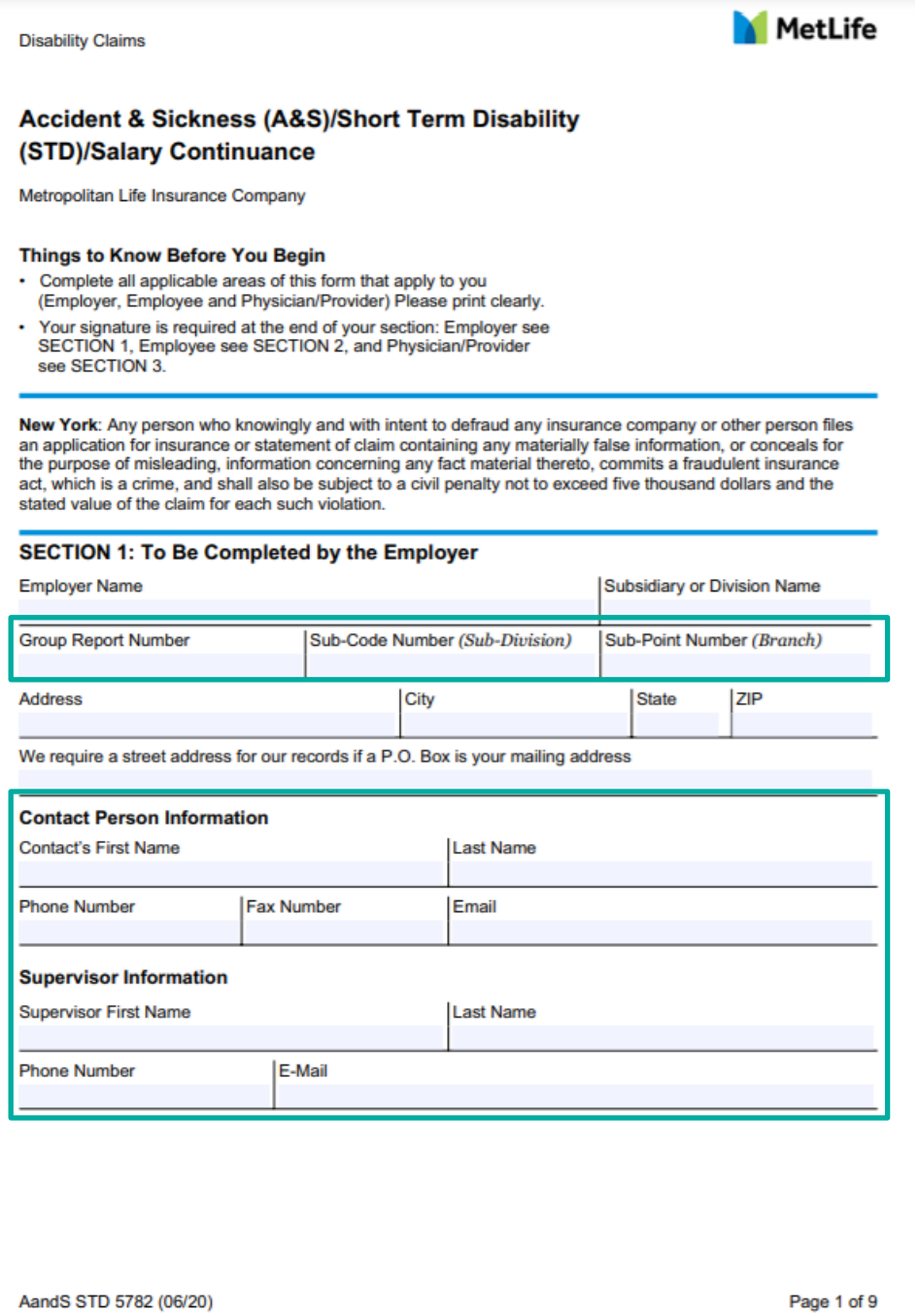
This guide provides helpful instructions on how to complete a MetLife Disability paper claim form.

Section 1: To be Completed by your Employer.

It's important that the employer participates in the claim filing process.

To speed up processing, the employer must complete this section of the claim form. If not, MetLife will send it to the employer, and they will have 10 business days to complete and return it.

- **Group Report, Sub-Code Number and Sub-Point Number:** Please contact your MetLife service team, if you don't have this information. **Please note**: Leaving this blank may slow down claim processing.
- **Address:** Please provide the employer address that was originally given when the policy was issued with MetLife.
- **Contact Person Information:** Enter the contact person who can answer questions regarding the company's benefit program and employee's employment details.
- **Supervisor Information:** Enter the employee's direct supervisor's contact information.



Disability Claims

MetLife

Accident & Sickness (A&S)/Short Term Disability (STD)/Salary Continuance

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Complete all applicable areas of this form that apply to you (Employer, Employee and Physician/Provider) Please print clearly.
- Your signature is required at the end of your section: Employer see SECTION 1, Employee see SECTION 2, and Physician/Provider see SECTION 3.

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: To Be Completed by the Employer

Employer Name | Subsidiary or Division Name

Group Report Number | Sub-Code Number *(Sub-Division)* | Sub-Point Number *(Branch)*

Address | City | State | ZIP

We require a street address for our records if a P.O. Box is your mailing address

Contact Person Information

Contact's First Name | Last Name

Phone Number | Fax Number | Email

Supervisor Information

Supervisor First Name | Last Name

Phone Number | E-Mail

AandS STD 5782 (06/20)

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Section 1: To be Completed by your Employer, continued...

- **Job Class:** Check <u>one</u> box that best describes the category of the employee's job requirements. The employee moves objects up to:
  - **Sedentary:** 10 lbs. (pounds) occasionally.
  - **Light:** 10 – 20 lbs. occasionally
  - **Medium:** 20 – 50 lbs. occasionally.
  - **Heavy:** 50 – 100 lbs. occasionally. and/or 25 – 50 lbs. frequently.
  - **Very Heavy:** More than 100 lbs. occasionally and/or 50 lbs.+ frequently.
- **Premium Contributions,** Benefit Amount and Payroll Classification: Please reach out to your HR Benefits and/or Payroll department to obtain this information. This is critical to tax benefit calculations.
- **To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the income sources listed:** Please review this section with your employee and check the box for each type of paid leave benefit the employee has applied for and/or will be receiving, including other paid leave (i.e., vacations). Also, provide the dollar amount, how often the employee expects to receive the paid benefit (frequency) and timeframe (from and to date).
- **Provide weekly deductions amounts (if applicable) :** Please locate the employee's paycheck and provide the payroll deductions amounts for each federal, state, and company withholdings, pre- and post-tax.

Employee Information

First Name | Middle Name | Last Name

Social Security Number | Employee ID Number *(if applicable)* | Date of Hire *(mm/dd/yyyy)*

Job Title | Work Phone Number

Job Class
☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Home Phone Number

Work Location Address | City | State | ZIP

Is condition work-related? ☐ Yes ☐ No If yes, provide:

Workers' Comp (WC) Carrier | Workers' Comp Claim Number | W/C Contact Person's Phone Number

W/C Contact Person - First Name | Last Name

Date Last Worked *(mm/dd/yyyy)* | First Date of Absence *(mm/dd/yyyy)* | Date Returned To Work *(mm/dd/yyyy)* ☐ Actual ☐ Estimated | Eff. Date of Coverage *(mm/dd/yyyy)*

Basic Earnings *(exclusive of overtime, bonus, etc.)*

$ ☐ Hourly ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Annual

Premium contributions ☐ Pre-Tax ☐ Post-Tax
Employer % Employee %

Benefit Amount

Payroll Classification
☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly
☐ Union ☐ Non-Union ☐ Other

Employee's Status as of First Day of Absence

☐ Active ☐ Vacation ☐ LOA ☐ Laid Off ☐ Terminated ☐ Retired

If other than Active, please explain

Hours Worked Per Week ☐ Full Time ☐ Part Time | Work Week ☐ Regular ☐ Variable

Scheduled Work Week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

If STD buy up, date enrollment card signed *(mm/dd/yyyy)* | LTD Coverage? ☐ Yes ☐ No | Has return to work been discussed with employee? ☐ Yes ☐ No

Can employee's job be modified/accommodated? ☐ Yes ☐ No If yes, please describe.

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 Date	To Date
Salary Continuance/Sick Leave	☐	☐				
COVID 19 Paid Sick Leave	☐	☐				
Worker's Compensation	☐	☐				
State Disability	☐	☐				
Other *(please identify)*	☐	☐				

Provide weekly deduction amounts, if applicable:

	Pre Tax	Post Tax	$ Weekly Amount
Medical	☐	☐	
Life	☐	☐	
Dental	☐	☐	
LTD	☐	☐	
Other *(please identify)*	☐	☐	

Sign Here Authorizing Employer Signature | Date *(mm/dd/yyyy)*

This is an official document; the **employer** must sign and date this section of the claim form.

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Section 2: To be Completed by Employee.

- **Federal Tax Status and Tax Exemptions:** Check the appropriate box to describe your federal tax status and provide the number of tax exemptions. This is critical to accurate calculation of taxes.
- **Provide Details:** Please provide any additional details related to your claim. If your claim is due to **pregnancy/ maternity**, please provide your expected delivery date and delivery type (Vaginal or Cesarean).
- **Is this condition work-related?:** Please confirm if your condition is work-related. If yes, you will need to provide MetLife with your workers compensation statement.
- **Name the physicians/providers who have treated you for this condition in the past 12 months:** Provide the contact information of the health care provider(s) treating you for your condition, including those who have advised you to stop/limit working. **Example:** If you undergo surgery, please provide us with contact information of your main treating physician (who diagnosed you), your surgeon, as well as treatment dates including date of surgery or hospitalization date(s).
- **Please describe what prevents you from performing the duties of your job:** Describe how your condition is preventing you from performing the duties of your job. **Example:** Having surgery may result in physical limitations (i.e., inability to walk/type/lift/etc.) for 4-6 weeks.

SECTION 2: To Be Completed by Employee

Some services in connection with your Disability Claim may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

First Name | Middle Name | Last Name

Social Security Number | Employee ID number *(if applicable)* | Date of Birth *(mm/dd/yyyy)* | Gender ☐ M ☐ F

Address | City | State | ZIP

We require a street address for our records if a P.O. Box is your mailing address | Email

Home Phone Number | Marital Status ☐ Married ☐ Single ☐ Other | Federal Tax Status ☐ Married ☐ Single | Tax Exemptions *(Number)*

Date Disability Began *(mm/dd/yyyy)* | Is your disability due to ☐ Illness? ☐ Injury/Accident? If due to injury/accident, provide | Date *(mm/dd/yyyy)* | Time ☐ AM ☐ PM

Provide Details *(Where and How)*

Is this condition work-related? ☐ Yes ☐ No Automobile-related? ☐ Yes ☐ No

Name of physicians/providers who have treated you for this condition within the past 12 months

Name of Physician/Provider	Phone Number	Dates of Treatment: From	Dates of Treatment: To	Physician/Provider Specialty

Please describe what prevents you from performing the duties of your job.

Sign Here | Employee Signature | Date *(mm/dd/yyyy)*

This is an official document; the **employee** must sign and date this section of the claim form.

Reminder: Please ensure you complete the **Authorization to Disclose Information About Me** at the end of the claim form.

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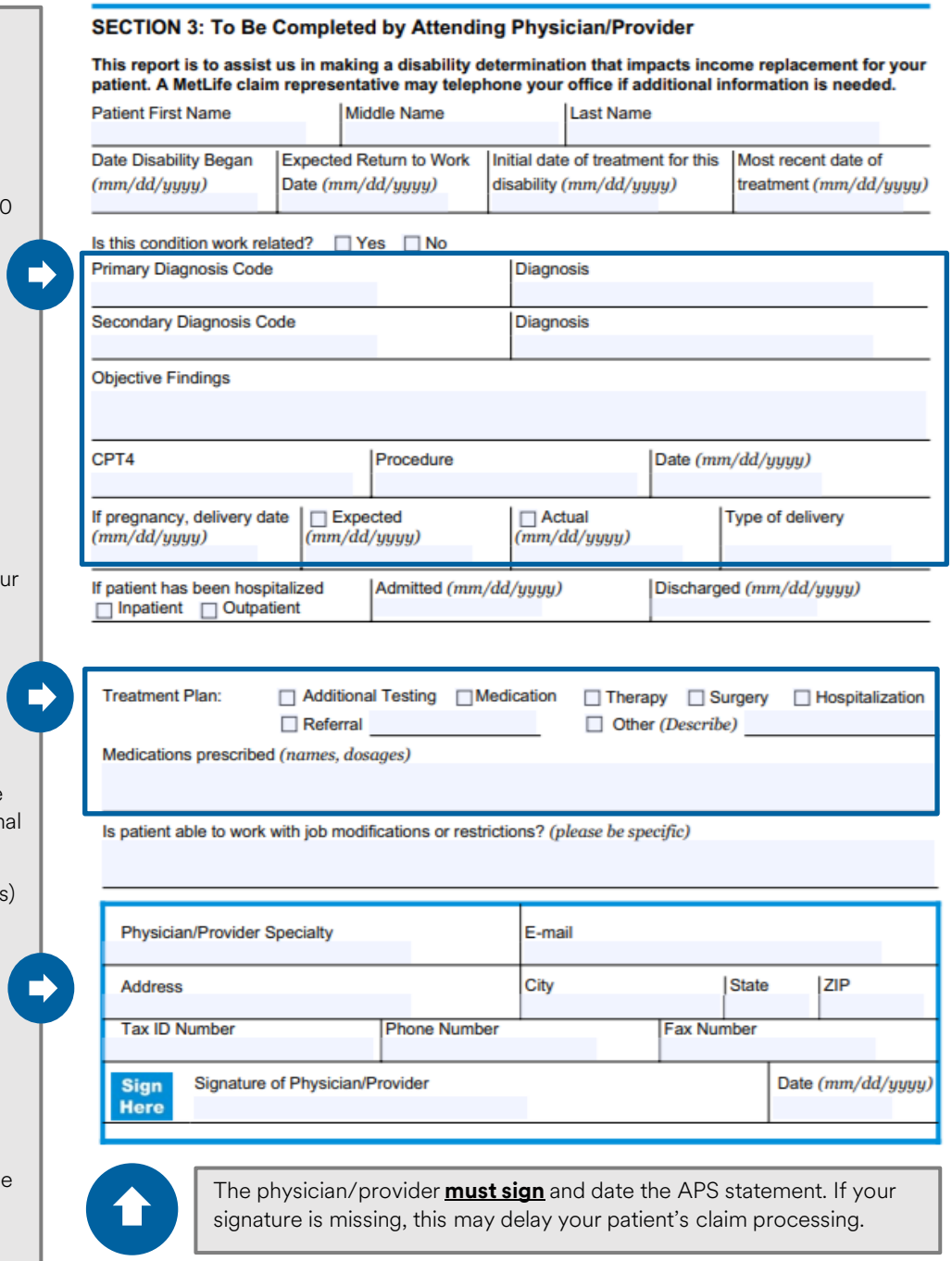
Section 3: To be Completed by Attending Physician/ Provider.

- **Primary and Secondary ICD-10 Diagnosis Code and Diagnosis Name:** Provide the Primary ICD-10 Diagnosis Code and Diagnosis Name. If applicable, provide the Secondary ICD-10 Diagnosis Code and Diagnosis Name.
- **Objective Findings:** Summarize your objective findings (to include test results, imaging studies, observed behaviors, functionality, etc.) that would assist us in evaluating the patient's claim for disability benefits.
- **CPT4, Procedure and Date:** If your patient will undergo a medical procedure, provide the CPT4 procedure code, description and date of the procedure.
- **Delivery Date:** If the patient is pregnant, please provide the delivery date or the expected date along with the delivery type (Vaginal or Cesarean).
- **Treatment Plan:** Select the box(es) that best defines your patient's treatment plan.
- **Medications Prescribed:** List current medications prescribed including dosages. Also, please include any discontinued medications, and dosages.
- **Contact information (blue box):** Provide contact information in case MetLife needs to contact you directly for additional information.



SECTION 3: To Be Completed by Attending Physician/Provider

This report is to assist us in making a disability determination that impacts income replacement for your patient. A MetLife claim representative may telephone your office if additional information is needed.

Patient First Name | Middle Name | Last Name

Date Disability Began *(mm/dd/yyyy)* | Expected Return to Work Date *(mm/dd/yyyy)* | Initial date of treatment for this disability *(mm/dd/yyyy)* | Most recent date of treatment *(mm/dd/yyyy)*

Is this condition work related? ☐ Yes ☐ No

Primary Diagnosis Code | Diagnosis

Secondary Diagnosis Code | Diagnosis

Objective Findings

CPT4 | Procedure | Date *(mm/dd/yyyy)*

If pregnancy, delivery date *(mm/dd/yyyy)* | ☐ Expected *(mm/dd/yyyy)* | ☐ Actual *(mm/dd/yyyy)* | Type of delivery

If patient has been hospitalized ☐ Inpatient ☐ Outpatient | Admitted *(mm/dd/yyyy)* | Discharged *(mm/dd/yyyy)*

Treatment Plan: ☐ Additional Testing ☐ Medication ☐ Therapy ☐ Surgery ☐ Hospitalization ☐ Referral ☐ Other *(Describe)*

Medications prescribed *(names, dosages)*

Is patient able to work with job modifications or restrictions? *(please be specific)*

Physician/Provider Specialty | E-mail

Address | City | State | ZIP

Tax ID Number | Phone Number | Fax Number

Sign Here | Signature of Physician/Provider | Date *(mm/dd/yyyy)*

The physician/provider **must sign** and date the APS statement. If your signature is missing, this may delay your patient's claim processing.

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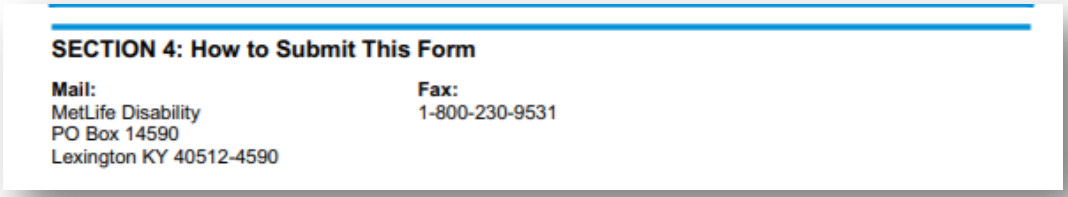
How to submit your paper claim form:

The **How to submit the form** section on the last page provides the mailing address or fax number to send your completed claim form to us.



SECTION 4: How to Submit This Form

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531

What happens after I submit my claim form?

- Please ensure you complete the **Authorization to Disclose Information About Me** at the end of the claim form.
- **Within 2-4 business days** of filing your claim with MetLife, you will receive an Acknowledgement Package with important information regarding your claim(s).
- A MetLife claims specialist may contact you for additional details about you, your job, your condition, your treatment plan and provider. Your claims specialist will also discuss your estimated return to work date.
- Employers will be contacted to confirm employment and coordinate other eligible benefits.
- We'll follow up with a letter detailing any missing information to complete your claim, if needed.
- MetLife will make a decision about your claim.
- Once a decision is made on your claim(s), you'll receive a letter outlining next steps and instructions on how to contact MetLife if you require further assistance.