LONG TERM DISABILITY CLAIM FORM EMPLOYER STATEMENT

MetLife®
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511
Fax: 1-800-230-9531

Instructions for completing the claim form:
1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this claim 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 ☐ M ☐ F
		mm/dd/yy	

Address City State ZIP Code	Home Phone #

Marital Status ☐ Married ☐ Single ☐ Other	W4 Filing Status_____ Exemptions:_____	Date of Hire	Current Occupation	How long at this occupation?
		mm/dd/yy		

Work Location Address	Employee ID #	Work Phone #

Supervisor Name	Phone #

Section 3: Claim Information

Is claim due to ☐ Injury? ☐ Illness?	Description of illness or injury (including date of accident):
Is condition work-related? ☐ Yes ☐ No	

If yes, provide name and address of Workers' Compensation Carrier.

Name _____ Address _____

Contact Person's Name _____ Phone #_____ Worker's Comp. Claim #_____

Date Last Worked MUST ANSWER	First Date of Absence	Date Returned to Work ☐ Actual ☐ Estimated	Eff. Date of Coverage	Earn. On Last Day Worked	Benefit Rate
mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy		

Premium Contributions Employer_____% Employee_____% ☐ Pre-tax ☐ Post-tax	Basic Earnings (exclusive of overtime, bonus, etc.) $_____ ☐ Hourly ☐ Weekly ☐ Monthly	Average Hours Worked Per Week

Employee's Status As Of First Day Absent ☐ Active ☐ LOA ☐ Terminated ☐ Vacation ☐ Laid Off ☐ Retired If other than active, Please explain	LTD: Date Enrollment Card Signed	If buy up: Date Enrollment Card Signed
	mm/dd/yy	mm/dd/yy

Has employee had previous absences from work due to disability? ☐ Yes ☐ No If yes, provide dates and medical conditions

Can employee's job be modified? ☐ Yes ☐ No If yes, describe how.	Has return to work been discussed with employee? ☐ Yes ☐ 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	☐	☐			mm/dd/yy mm/dd/yy
Short Term Disability	☐	☐			mm/dd/yy mm/dd/yy
Workers' Compensation	☐	☐			mm/dd/yy mm/dd/yy
State Disability	☐	☐			mm/dd/yy mm/dd/yy
Social Security	☐	☐			mm/dd/yy mm/dd/yy
Dependent Social Security	☐	☐			mm/dd/yy mm/dd/yy
No Fault (Income Replacement)	☐	☐			mm/dd/yy mm/dd/yy
Retirement/Pension	☐	☐			mm/dd/yy mm/dd/yy
Permanent Total Disability	☐	☐			mm/dd/yy mm/dd/yy
Other (Please identify)	☐	☐			mm/dd/yy mm/dd/yy

Continued on following page

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: mm/dd/yy

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				
	0	1-2	3-4	5-6	7-8+
1. Sitting					
2. Standing					
3. Walking					
4. Bending Over					
5. Twisting					
6. Climbing					
7. Reaching Above Shoulder Level					
8. Crouching/Stooping					
9. Kneeling					
10. Balancing					
11. Pushing and Pulling					
12. Repetitive Use of Foot Control					
A. Right Foot Only					
B. Left Foot Only					
C. Both Feet					
13. Repetitive Use of Hands					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					

	Number of hours per work shift				
	0	1-2	3-4	5-6	7-8+
14. Grasping					
A. Simple/Light					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
B. Firm/Strong					
1. Right Hand Only					
2. Left Hand Only					
3. Both Hands					
15. Fine Finger Dexterity					
A. Right Hand Only					
B. Left Hand Only					
C. Both Hands					
16. Use of Head and Neck in:					
A. Static Position					
B. Twisting					
C. Looking Up					
D. Looking Down					

	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
20. Drive cars, trucks, forklifts and/or other equipment		
21. Be around moving equipment and/or machinery		
22. Walk on uneven ground		

	Yes	No
23. Be exposed to dust, gas, or fumes		
if yes, are respirators required		
24. Be exposed to marked changes in temperature or humidity		
25. Is overtime required on a routine basis		

Continued on following page

Disability Claim Statement (Continued)

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

Fraud Warning:

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 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.

Fraud Warning *(continued)*:

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

Fraud Warning *(continued)*:

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.

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.

Employer's Authorized Representative

Name _____ Title: _____ Phone # _____

Signature _____ Date: mm/dd/yy