

Exceptional service from experienced professionals

Our highly trained, compassionate specialists support and guide your employees throughout the claims process with the goal of helping them to return to health.



Submission and Initial Evaluation

- Claimant submits claim by phone, web or mail
- They can access all forms online via their MyBenefits portal
- Claims Specialist reviews all medical information and contacts their treatment provider directly to determine eligibility under the disability plan
- Auto-adjudication delivers efficient claims processing

FAST: We attempt to contact the Claimant within 1-2 business days and provide direct access to their Claims Specialist

Initial Decision

- We make a claims decision within 2 business days of receiving all necessary information
- The Claims Specialist:
 - » Develops an action plan
 - » Identifies treatment providers and a timeline for the Claimant
 - » Evaluates expected disability duration with an anticipated return to work date
 - » Explains next steps to the Claimant

EFFICIENT: About ½ of STD claims are eligible for decisions within 1 business day, with over ½ of those decisions being made instantly

Ongoing Service and Follow Up

- Clinicians clarify medical information, confirm treatment plans and validate disability benefits, with rehabilitation consultants when appropriate
- We provide analytics-driven referrals at the right points for clinical intervention
- We plan ahead for Long Term Disability and enable automatic claim bridging for a smooth transition
- We continue to update the action plan, assess the claim, follow up with treatment providers and connect with the Claimant
- Simplified and convenient access to self-service tools and their Claims Specialist, including 2-way texting and video chat support

PROACTIVE: 6-8 weeks before the benefit start date, we will initiate a LTD claim to avoid payment delays, if also covered

Claim and Leave Resolution

- We help with on-site job modification and other return to work accommodations, where appropriate
- The Claimant can move to LTD without additional claim applications. The information is automatically transferred and updated as required
- We advise the Claimant by phone and letter when the claim is closed or when a LTD benefit decision is made, and notify their employer of the resolution online

ENGAGED: 7 days before the end of the Disability Benefit, the Claims Specialist will confirm the RTW plan with all parties

The Claims Specialist connects the Claimant to your health and wellness programs, and engages specialists throughout the claim as needed, including:

- » Rehabilitation Consultants
- » Nurses
- » Behavioral Clinicians
- » Physician Consultants
- » Social Security Specialists

Navigating life together

An optimized online experience

Our online resources are designed to provide you and your employees with self-service support that keeps everyone informed, involved and engaged.

For You

Employers can use MyBenefits or MetLink to:

- Submit claims online
- Obtain real-time claim status and details
- Create custom reports
- Update information and add comments to existing claims

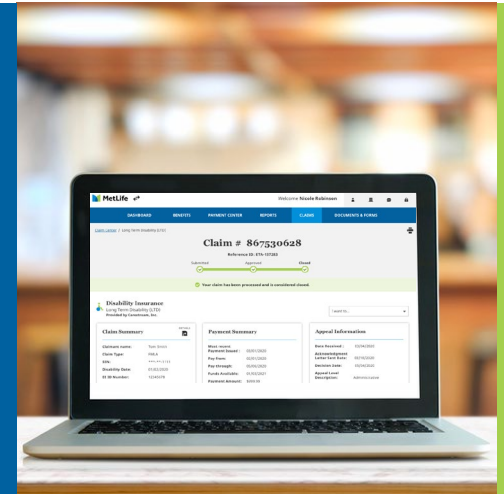
Employers can submit a claim for an employee on MyBenefits and manage their workforce.

For Your Employees

Employees can use MyBenefits and the MetLife MobileApp to:

- Submit a claim*
- Authorize an Electronic Funds Transfer
- Submit medical authorization
- Submit medical information and comments
- Review real-time claim status
- Access educational videos

* not available through the mobile app



Special Considerations: If you have employees who work in a state with state-mandated disability or paid medical leave benefits (“State Benefits”), they should carefully consider whether to enroll for this coverage. In California, Connecticut, Hawaii, Massachusetts, New Jersey, New York, Puerto Rico, Rhode Island, Washington, Oregon (starting 9/3/23), and Colorado (starting 1/1/24), if eligible, employees must apply for State Benefits. Your employees’ STD benefit will be reduced by State Benefits or other government benefits that apply. Depending on your employees’ compensation, the amount of the State Benefit, and other factors, they may only receive the minimum weekly benefit. Your employees should consider, based on their individual circumstances, whether they need additional coverage beyond the State Benefit.

[Get expert guidance for confident decisions.](#)

Contact your MetLife representative today.

[metlife.com](https://www.metlife.com)

The timeline is an example of an STD claim bridging to an LTD claim based on calendar days. The specific timing of events on each claim is driven by many factors including plan design, the disabling condition, the claimant’s occupation and more. Claim submission methods may vary by product and customer size. Metropolitan Life Insurance Company, New York, NY.

Like most group disability insurance policies, MetLife’s policies contain certain exclusions, waiting periods, reductions, limitations and terms for keeping them in force. Ask your representative about costs and complete details.



Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166

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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 (<i>Sub-Division</i>)	Sub-Point Number (<i>Branch</i>)	
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	

Employee Information

First Name	Middle Name	Last Name
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Social Security Number	Employee ID Number (if applicable)	Date of Hire (mm/dd/yyyy)
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Job Title	Work Phone Number
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Job Class Sedentary Light Medium Heavy Very Heavy	Home Phone Number
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Work Location Address	City	State	ZIP
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Is condition work-related? Yes No If yes, provide:

Workers' Comp (WC) Carrier	Workers' Comp Claim Number	W/C Contact Person's Phone Number
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W/C Contact Person - First Name	Last Name
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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)
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Basic Earnings (exclusive of overtime, bonus, etc.)

\$ _____ Hourly Weekly Bi-weekly Monthly Annual

Premium contributions	Pre-Tax	Post-Tax	Benefit Amount	Payroll Classification
Employer _____ %	Employee _____ %			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
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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
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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)
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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
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We require a street address for our records if a P.O. Box is your mailing address	Email
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Home Phone Number	Marital Status Married Single Other	Federal Tax Status Married Single	Tax Exemptions (Number)
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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
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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)
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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 <i>(mm/dd/yyyy)</i>	Expected Return to Work Date <i>(mm/dd/yyyy)</i>	Initial date of treatment for this disability <i>(mm/dd/yyyy)</i>
		Most recent date of treatment <i>(mm/dd/yyyy)</i>

Is this condition work related? Yes No

Primary Diagnosis Code	Diagnosis
Secondary Diagnosis Code	Diagnosis

Objective Findings

CPT4	Procedure	Date <i>(mm/dd/yyyy)</i>
If pregnancy, delivery date <i>(mm/dd/yyyy)</i>	Expected <i>(mm/dd/yyyy)</i>	Actual <i>(mm/dd/yyyy)</i>
		Type of delivery
If patient has been hospitalized Inpatient Outpatient	Admitted <i>(mm/dd/yyyy)</i>	Discharged <i>(mm/dd/yyyy)</i>

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)

SECTION 4: How to Submit This Form

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


Fax:
 1-800-230-9531

Authorization to Disclose Information About Me

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Section 2 requires your signature.
- Return this form as soon as possible to expedite processing of your claim as described in Section 3 and keep a copy for your records.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant’s behalf and include the claim number at the top of each page.

 Your refusal to complete and sign this form may affect your eligibility for Benefits.

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).

NOTE TO ALL HEALTH CARE PROVIDERS:

The Genetic Information Nondiscrimination Act of 2008 (*GINA*) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 1: Claimant Information

First Name	Middle Name	Last Name
Date of Birth (<i>mm/dd/yyyy</i>)	Claim Number	ID Number (<i>if applicable</i>)

SECTION 2: Authorization & Signature

For purposes of determining my eligibility for disability benefits or request for reasonable accommodation under the Americans with Disabilities Act (*ADA*), the administration of my disability benefit plan (*which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits*), and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any Workers’ Compensation, employee assistance or disease management program, 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/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to Metropolitan Life Insurance Company (“*MetLife*”), 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 disability claim.
2. **I permit:** MetLife to disclose to my employer or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, Workers’ Compensation, employee assistance, or disease management programs, any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me 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 Disability at PO Box 14590, Lexington KY 40512-4590, 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.

Sign Here	Claimant's Signature	Date (mm/dd/yyyy)
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SECTION 3: How to Submit This Form

Mail:

MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:

1-800-230-9531

Fraud Warnings

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 to the extent required by applicable law.

Delaware: 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.

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

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.

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 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 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: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

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.

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.

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.

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



MetLife Contacts

Disability

Disability Claims

Phone: 1-800-300-4296 – for quicker service, have your claim number or SSN ready when you call

Fax: 1-800-230-9531

Mail: PO Box 14590, Lexington, KY 40511-4590