NASE 07.2012

MetLife®

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center

Critical Illness Insurance Death Benefit Claim Form

Claim Number:_____ **(for home office use only)**

P.O. Box 6120
Scranton, PA 18505-9972
Toll Free Phone: 1 800 GET-MET 8
Fax Number: 1-866-268-2621

SECTION A: Policyowner/Insured Information

Policyowner/Insured Name	Gender	Date of Birth (Mo./Day/Yr)	Member ID Number	Social Security Number
		mm/dd/yy		

Address (Street)	City	State	Zip Code	Daytime Phone Number

SECTION B: Patient/Deceased Statement

(Please use the Claimants Statement Section on the next page if providing additional Claimants Statements.)

Name (First, Middle Initial, Last Name) Dr, Mr, Mrs,Ms,	☐ Spouse ☐ Child ☐ Same as Above	Date of Birth (Mo./Day/Yr)	Social Security Number
		mm/dd/yy	

Address (Street)	City	State	Zip Code

Contact Information

Contact Name

Address (Street)	City	State	Zip Code

Phone Number	Relationship to Deceased

SECTION C: What Type Of Condition Are You Claiming?

Please check off the cause or manner of death and provide copy of the Death Certificate and complete Physicians or Supplier Statement:

☐ Full Benefit Cancer	☐ Partial Benefit Cancer	☐ Coronary Artery Bypass Graft
☐ Heart Attack	☐ Stroke	☐ End Stage Kidney Failure
☐ Bone Marrow Transplant	☐ Heart Transplant	☐ Major Organ Transplant

SECTION D: Special Instructions

- **Please provide a copy of the Insured Death Certificate.**
- Use the space below to provide any special instructions (e.g., requesting that your claim proceeds be sent to an address other than the address of record).

Press "tab" to advance to the next line.

(Continued on Following Page)

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Use this page if additional claimants statements are needed.

SECTION B: Claimants Statement		
Name (First, Middle Initial, Last Name) Dr, Mr, Mrs,Ms,	Date of Birth (Mo./Day/Yr) mm/dd/yy	Social Security Number
Address (Street) City State Zip Code		
Relationship to Insured	Daytime Phone Number	

SECTION B: Claimants Statement		
Name (First, Middle Initial, Last Name) Dr, Mr, Mrs,Ms,	Date of Birth (Mo./Day/Yr) mm/dd/yy	Social Security Number
Address (Street) City State Zip Code		
Relationship to Insured	Daytime Phone Number	

SECTION B: Claimants Statement		
Name (First, Middle Initial, Last Name) Dr, Mr, Mrs,Ms,	Date of Birth (Mo./Day/Yr) mm/dd/yy	Social Security Number
Address (Street) City State Zip Code		
Relationship to Insured	Daytime Phone Number	

(Continued on Following Page)

Fraud Warning:

If you reside in or are insured under a policy issued in one of the following states, please read the applicable warning:

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.

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.

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.

Delaware, 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.

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

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, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial or insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 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.

Fraud Warning *(continued)*:

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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 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.

Name of Claimant (Please Print):	Social Security Number:
Signature of Claimant or Authorized Representative:	Date: mm/dd/yy

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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).

Instructions for completing the form:

1. **Complete all applicable areas of the form.**
2. **If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Beneficiary's/Claimant's behalf.**
3. **Sign this form.**
4. **Fax or return this form as soon as possible to expedite processing of your claim - retain original for your records.**

Name of Claimant or Beneficiary (Please Print)

mm/dd/yy
Deceased's Date of Birth

Name of Deceased

Authorization to Disclose Health Information

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), the deceased's employer in its capacity as administrator of its critical illness benefit plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about the deceased's health, medical care, employment, and critical illness claim.
2. **I permit** MetLife and the deceased's employer (if applicable) to disclose in its capacity as administrator of its benefit plans any and all information about the deceased's health, medical care, employment, and critical illness claim.

This Authorization to Disclose Health Information specifically includes my permission to disclose the deceased's 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.**

I understand that I may revoke this authorization at any time by writing to MetLife Critical Illness Insurance at **P.O. Box 6120, Scranton, PA 18505-9972**, 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 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.

Signature of Claimant or Authorized Representative

mm/dd/yy
Date

If signed by Authorized Representative, describe your authority (e.g., guardian, conservator, power of attorney, etc.) and provide documentation.

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Physician or Supplier Statement

Please sign the Authorization to Disclose Health Information and submit it with this form to your Physcian/Supplier.

I authorize the release of any medical information necessary to process this claim.

Signed _____ **Date** mm/dd/yy

Relationship to Insured _____

SECTION D: Please ask your Physician/Provider to complete the information below

Patient's Name (First, Middle Initial, Last Name)	Patient's Gender	Patient's Birth Date
		mm/dd/yy

Address (Street) (City) (State) (Zip Code)	Daytime Phone Number

Please check off the cause or manner of death:

☐ Full Benefit Cancer	☐ Partial Benefit Cancer	☐ Coronary Artery Bypass Graft
☐ Heart Attack	☐ Stroke	☐ End Stage Kidney Failure
☐ Bone Marrow Transplant	☐ Heart Transplant	☐ Major Organ Transplant

Date of Illness (First Symptom/ Diagnosis Date):	Date your patient first consulted you for this condition:	Has the patient previously had same or similar condition? ☐ Yes ☐ No If "yes," indicate first treatment dates:
mm/dd/yy	mm/dd/yy	

Name of referring and other treating Physicians

Name _____ Phone _____

Address: _____

Name _____ Phone _____

Address: _____

Name: _____ Phone _____

Address: _____

For services related to hospitalization, give hospitalization dates:

Date Confined mm/dd/yy Through mm/dd/yy Hospital Name(s)/Address _____

Date Confined mm/dd/yy Through mm/dd/yy Hospital Name(s)/Address _____

Date Confined mm/dd/yy Through mm/dd/yy Hospital Name(s)/Address _____

Please provide the relevant medical documentation as noted below.

History and Medical Documentation needed based on condition checked:

- Full Benefit Cancer – Pathology Reports, surgical reports and TMN Stage: _____
- Partial Benefit Cancer – Pathology Reports, surgical reports and TMN Stage: _____
- Coronary Artery Bypass Surgery – Open heart surgical reports
- End Stage Kidney Failure – Kidney Specialist records or dialysis records
- Heart Attack – All of the following: Hospital Summary, EKGs, Cardiac Enzymes. If completed, provide any of the following: Thallium Scans, Muga Scans, Stress echocardiogram, Cardiac Catheterization Report
- Bone Marrow, Heart or Major Organ Transplant – Surgical Report and Clinical Records
- Stroke – Documented Neurological deficits, Neuroimaging studies, Clinical Records and Documentation of deficits 30 days post event.

Medical Provider Signature and Medical Specialty:

Please Print Your Name: _____ Phone Number: _____

Signed: _____ Medical Specialty: _____ Date: mm/dd/yy

Address: _____

Street City State Zip Code