



Metropolitan Life Insurance Company  
Attn: Critical Illness Insurance Service Center

## Critical Illness Insurance Claim Form

Claim Number: \_\_\_\_\_ (for home office use only)

SECTION A: Insured/Certificate Holder Information				
Insured/Certificate Holder Name (First, Middle Initial, Last Name)	Gender	Date of Birth	Member ID Number	Social Security Number
Address (Street)		City	State	Zip Code
				Daytime Phone Number

SECTION B: Patient Information					
Name (First, Middle Initial, Last Name)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Same as Above		Gender	Date of Birth	Social Security Number
Address (Street)		City	State	Zip Code	
Daytime Phone Number		Evening Phone Number			

SECTION C: What Type Of Condition Are You Claiming?		
Please check off the condition that applies to your claim:		
<input type="checkbox"/> Full Benefit Cancer	<input type="checkbox"/> Partial Benefit Cancer	<input type="checkbox"/> Coronary Artery Bypass Graft
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> End Stage Kidney Failure
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Major Organ Transplant

SECTION D: Special Instructions
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).

(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 of 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:



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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 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.

Your refusal to complete and sign this form may affect your eligibility for benefits under your critical illness insurance policy.

\_\_\_\_\_  
Name of Claimant or Authorized Representative (Please Print)

\_\_\_\_\_  
Date of Birth

### Authorization to Disclose Health Information

For purposes of determining my eligibility for critical illness benefits, the administration of my critical illness benefit plan (which may include assisting me in returning to work), and the administration of other benefit plans in which I participate that may be affected by my eligibility for critical illness benefits, 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/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my 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 my health, medical care, employment, and critical illness claim.
2. **I permit** MetLife and my employer (if applicable) to disclose in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and critical illness 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 Critical Illness at

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.

\_\_\_\_\_  
Signature of Claimant or Authorized Representative

\_\_\_\_\_  
Date

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

**Physician or Supplier Statement**



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

<b>I authorize the release of any medical information necessary to process this claim.</b>			
Signed _____		Date _____	
Relationship to Insured _____			
<b>SECTION D: Please ask your Physician/Provider to complete the information below</b>			
Patient's Name (First, Middle Initial, Last Name) _____		Patient's Gender _____	Patient's Birth Date _____
Address (Street) _____ (City) _____ (State) _____ (Zip Code) _____		Daytime Phone Number _____	
Check off the condition with which your patient has been diagnosed/treated:			
<input type="checkbox"/> Full Benefit Cancer	<input type="checkbox"/> Partial Benefit Cancer	<input type="checkbox"/> Coronary Artery Bypass Graft	
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke	<input type="checkbox"/> End Stage Kidney Failure	
<input type="checkbox"/> Bone Marrow Transplant	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," indicate first treatment dates: _____	
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 _____ Through _____		Hospital Name(s)/Address _____	
Date Confined _____ Through _____		Hospital Name(s)/Address _____	
Date Confined _____ Through _____		Hospital Name(s)/Address _____	
<b>Please provide the relevant medical documentation as noted below.</b>			
<b>History and Medical Documentation needed based on condition checked:</b>			
<ul style="list-style-type: none"> <li>• Full Benefit Cancer – Pathology Reports, surgical reports and TMN Stage: _____</li> <li>• Partial Benefit Cancer – Pathology Reports, surgical reports and TMN Stage: _____</li> <li>• Coronary Artery Bypass Surgery – Open heart surgical reports</li> <li>• End Stage Kidney Failure – Kidney Specialist records or dialysis records</li> <li>• 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</li> <li>• Bone Marrow, Heart or Major Organ Transplant – Surgical Report and Clinical Records</li> <li>• Stroke – Documented Neurological deficits, Neuroimaging studies, Clinical Records and Documentation of deficits 30 days post event.</li> </ul>			
<b>Medical Provider Signature and Medical Specialty:</b>			
Please Print Your Name: _____		Phone Number: _____	
Signed: _____		Medical Specialty: _____ Date: _____	
Address: _____		_____	
Street	City	State	Zip Code