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	Policy Number	Social Security Number

Address (Street)	City	State	Zip Code	Daytime Phone Number

SECTION B: Patient Information

Name (First, Middle Initial, Last Name)	☐ Self ☐ Spouse ☐ Child ☐ 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:

☐ Full Benefit Cancer
☐ Partial Benefit Cancer
☐ Coronary Artery Bypass Graft
☐ Heart Attack
☐ Stroke
☐ Alzheimer's Disease
☐ Kidney Failure
☐ Major Organ Transplant

Listed Conditions (check the Listed Condition(s) being claimed):

☐ Addison's disease (adrenal hypofunction)
☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
☐ Cerebral palsy
☐ Cerebrospinal meningitis (bacterial)
☐ Cystic fibrosis
☐ Diphtheria
☐ Encephalitis
☐ Huntington's disease (Huntington's chorea)
☐ Legionnaire's disease
☐ Malaria
☐ Multiple sclerosis (definitive diagnosis)
☐ Muscular dystrophy
☐ Myasthenia gravis
☐ Necrotizing fasciitis
☐ Osteomyelitis
☐ Poliomyelitis
☐ Rabies
☐ Sickle cell anemia (excluding sickle cell trait)
☐ Systemic lupus erythematosus (SLE)
☐ Systemic sclerosis (scleroderma)
☐ Tetanus
☐ Tuberculosis

(Continued on Following Page)

SECTION D: 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:

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.

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 any 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 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 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)*:

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.

Certification and Signature:

By signing below, I acknowledge:

1. All information I have given is true and complete to the best of my knowledge and belief.
2. I have read the applicable Fraud Warning(s) provided in this form. **New York Residents: 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 claim for each such violation.**

Under penalty of perjury, I certify:

1. **That the number shown on this form is my correct taxpayer identification number; and**
2. **That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and**
3. **I am a U.S. citizen, or a U.S. resident for tax purposes.**

Please note: If item 2 or 3 above is not true, cross out the applicable item(s). The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Name of Claimant (Please Print):	**Social Security Number:**
Signature of Claimant or Authorized Representative:	**Date:**

Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center

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, 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.

MetLife®
Metropolitan Life Insurance Company
Attn: Critical Illness Insurance Service Center

Physician or Supplier Statement

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

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

Signed ______________________ **Date** ______________________

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

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

Check off the condition with which your patient was diagnosed / treated for:

- ☐ Full Benefit Cancer
- ☐ Partial Benefit Cancer
- ☐ Coronary Artery Bypass Graft
- ☐ Heart Attack
- ☐ Stroke
- ☐ Alzheimer's Disease
- ☐ Kidney Failure
- ☐ Major Organ Transplant

Listed Conditions (check the Listed Condition(s) being claimed):

- ☐ Addison's disease (adrenal hypofunction)
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Cerebrospinal meningitis (bacterial)
- ☐ Cystic fibrosis
- ☐ Diphtheria
- ☐ Encephalitis
- ☐ Huntington's disease (Huntington's chorea)
- ☐ Legionnaire's disease
- ☐ Malaria
- ☐ Multiple sclerosis (definitive diagnosis)
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Necrotizing fasciitis
- ☐ Osteomyelitis
- ☐ Poliomyelitis
- ☐ Rabies
- ☐ Sickle cell anemia (excluding sickle cell trait)
- ☐ Systemic lupus erythematosus (SLE)
- ☐ Systemic sclerosis (scleroderma)
- ☐ Tetanus
- ☐ Tuberculosis

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: ______________

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 ______________

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. • Listed Conditions - Specialist records, Lab results, Records showing observation of signs, symptoms and tests that led to the Diagnosis of the Listed condition.
Medical Provider Signature and Medical Specialty: Please Print Your Name: ______________________________ Phone Number: ____________________ Signed: ______________________________ Medical Specialty: ____________________ Date: ______________ Address: ____ Street City State Zip Code