

# LONG TERM DISABILITY CLAIM FORM EMPLOYER STATEMENT

# MetLife®

Metropolitan Life Insurance Company  
P.O. Box 14590  
Lexington, KY 40512  
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<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Address                                                                                                           |                                             | City                            | State              | ZIP Code                     | Home Phone #                                                 |
| Marital Status<br><input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other | W4 Filing Status _____<br>Exemptions: _____ | Date of Hire                    | Current Occupation | How long at this occupation? |                                                              |
| Work Location Address                                                                                             |                                             |                                 | Employee ID #      | Work Phone #                 |                                                              |
| Supervisor Name                                                                                                   |                                             |                                 |                    | Phone #                      |                                                              |

## Section 3: Claim Information

|                                                                                                                                                                       |                       |                                                                                                                                                                                                             |                                                                                                                                                                  |                              |                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-------------------------------------------|
| Is claim due to <input type="checkbox"/> Injury? <input type="checkbox"/> Illness?                                                                                    |                       | Description of illness or injury (including date of accident):                                                                                                                                              |                                                                                                                                                                  |                              |                                           |
| Is condition work-related? <input type="checkbox"/> Yes <input type="checkbox"/> 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<br>MUST ANSWER                                                                                                                                       | First Date of Absence | Date Returned to Work <input type="checkbox"/> Actual<br><input type="checkbox"/> Estimated                                                                                                                 | Eff. Date of Coverage                                                                                                                                            | Earn. On Last Day Worked     | Benefit Rate                              |
| Premium Contributions<br>Employer _____% Employee _____%                                                                                                              |                       | <input type="checkbox"/> Pre-tax<br><input type="checkbox"/> Post-tax                                                                                                                                       | Basic Earnings (exclusive of overtime, bonus, etc.)<br>\$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly |                              | Average Hours Worked<br>Per Week          |
| Employee's Status As Of First Day Absent<br>If other than active, Please explain                                                                                      |                       | <input type="checkbox"/> Active <input type="checkbox"/> Vacation<br><input type="checkbox"/> LOA <input type="checkbox"/> Laid Off<br><input type="checkbox"/> Terminated <input type="checkbox"/> Retired | LTD:<br>Date Enrollment Card Signed                                                                                                                              |                              | If buy up:<br>Date Enrollment Card Signed |
| Has employee had previous absences from work due to disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide dates and medical conditions |                       |                                                                                                                                                                                                             |                                                                                                                                                                  |                              |                                           |
| Can employee's job be modified? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe how.                                                        |                       |                                                                                                                                                                                                             | Has return to work been discussed with employee?<br><input type="checkbox"/> Yes <input type="checkbox"/> 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 | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Short Term Disability         | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Workers' Compensation         | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| State Disability              | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Social Security               | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Dependent Social Security     | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| No Fault (Income Replacement) | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Retirement/Pension            | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Permanent Total Disability    | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |
| Other (Please identify)       | <input type="checkbox"/> | <input type="checkbox"/> | _____     | _____     | _____         |

## 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: \_\_\_\_\_

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 |     |     |     |      |     |                          | Number of hours per work shift |     |     |     |      |
|-----|--------------------------------|--------------------------------|-----|-----|-----|------|-----|--------------------------|--------------------------------|-----|-----|-----|------|
|     |                                | 0                              | 1-2 | 3-4 | 5-6 | 7-8+ |     |                          | 0                              | 1-2 | 3-4 | 5-6 | 7-8+ |
| 1.  | Sitting                        |                                |     |     |     |      | 14. | Grasping                 |                                |     |     |     |      |
| 2.  | Standing                       |                                |     |     |     |      | A.  | Simple/Light             |                                |     |     |     |      |
| 3.  | Walking                        |                                |     |     |     |      | 1.  | Right Hand Only          |                                |     |     |     |      |
| 4.  | Bending Over                   |                                |     |     |     |      | 2.  | Left Hand Only           |                                |     |     |     |      |
| 5.  | Twisting                       |                                |     |     |     |      | 3.  | Both Hands               |                                |     |     |     |      |
| 6.  | Climbing                       |                                |     |     |     |      | B.  | Firm/Strong              |                                |     |     |     |      |
| 7.  | Reaching Above Shoulder Level  |                                |     |     |     |      | 1.  | Right Hand Only          |                                |     |     |     |      |
| 8.  | Crouching/Stooping             |                                |     |     |     |      | 2.  | Left Hand Only           |                                |     |     |     |      |
| 9.  | Kneeling                       |                                |     |     |     |      | 3.  | Both Hands               |                                |     |     |     |      |
| 10. | Balancing                      |                                |     |     |     |      | 15. | Fine Finger Dexterity    |                                |     |     |     |      |
| 11. | Pushing and Pulling            |                                |     |     |     |      | A.  | Right Hand Only          |                                |     |     |     |      |
| 12. | Repetitive Use of Foot Control |                                |     |     |     |      | B.  | Left Hand Only           |                                |     |     |     |      |
| A.  | Right Foot Only                |                                |     |     |     |      | C.  | Both Hands               |                                |     |     |     |      |
| B.  | Left Foot Only                 |                                |     |     |     |      | 16. | Use of Head and Neck in: |                                |     |     |     |      |
| C.  | Both Feet                      |                                |     |     |     |      | A.  | Static Position          |                                |     |     |     |      |
| 13. | Repetitive Use of Hands        |                                |     |     |     |      | B.  | Twisting                 |                                |     |     |     |      |
| A.  | Right Hand Only                |                                |     |     |     |      | C.  | Looking Up               |                                |     |     |     |      |
| B.  | Left Hand Only                 |                                |     |     |     |      | D.  | Looking Down             |                                |     |     |     |      |
| C.  | Both Hands                     |                                |     |     |     |      |     |                          |                                |     |     |     |      |

|                                                                           | Never<br>0% Of Time | Occasionally<br>1-33% Of Time | Frequently<br>34-66% Of Time | Continually<br>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:

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

| Yes | No |
|-----|----|
|     |    |
|     |    |
|     |    |

## 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: \_\_\_\_\_