Group Accident Insurance Claim Form

Metropolitan Life Insurance Company

Important Instructions for Requesting Accident Benefits

- If this is an Initial Claim for an accident, please complete each section in its entirety. *(An accident is not considered reported to us until a claim form is received).*
- If this is an additional claim for an accident previously reported *(i.e. - initial claim previously submitted and additional services were incurred)*, no claim form is required. Please provide itemized bills or treatment notes for the additional services. Include your claim number and/or certificate number on all pages of your submission.
- Please provide supporting documentation from the healthcare provider related to the injuries and services received for which a claim is being made. The supporting documents MUST include 1) patient's name, 2) service dates, 3) diagnosis, 4) specific procedure or treatment.
- Documentation that might be helpful to MetLife in making a claim decision includes the following items: Itemized invoices received for services as a result of this accident. You may need to ask your healthcare provider to provide you with a UB-04 form or other documentation. If you have an Explanation of Benefits (EOB), please also include this documentation.
- If treated in an emergency room, please provide a copy of the discharge papers from the hospital.
- If treated in an emergency room, please provide a copy of the discharge papers from the hospital.
- If admitted to a hospital, provide documentation from the hospital that details admission and discharge dates, diagnosis and room assignment *(ICU and/or Non ICU)*.
- If you were tested for alcohol or drugs in connection with an accident or injury please provide a copy of the drug screening or blood alcohol report.
- If the injury was the result of a motor vehicle accident, please provide a copy of the motor vehicle accident report.
- If the patient is deceased, we will need a copy of the death certificate.
- You must sign and submit the **Authorization to Disclose Health Information** form *(attached)*.
- Please refer to your certificate of insurance for a listing of specific benefits covered under your plan.

Failure to complete all sections of this claim form may delay processing this claim. To prevent possible delays, please be sure to provide all documentation from your healthcare provider that supports this claim. You will be notified in writing if additional information is needed to process your claim.

SECTION 1: Certificateholder Information *(Participant)*

Certificateholder name - First	Middle initial	Last name

Address - Street	City	State	Zip code

Certificate number	Date of birth *(mm/dd/yyyy)*	Social Security number	Gender ☐ Male ☐ Female

Cell phone number	Daytime phone number	Evening phone number	EMAIL address *(optional)*

Employer name

SECTION 2: Patient Information

☐ Same as Section 1 *(If you check this box, you do not need to complete this section. You may skip to Section 3.)*

☐ Spouse ☐ Child

Patient name - First	Middle initial	Last name

Home address - Street	City	State	Zip code

Date of birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female	Social Security number

Cell phone number	Daytime phone number	Evening phone number

SECTION 3: Accident Details

Please provide the following accident claim details.

Date of accident *(mm/dd/yyyy)*	Where did the accident occur?

City where accident occurred	State where accident occurred

Describe how the accident occurred. Describe what you were doing and how you were injured *(Include additional information on a separate sheet of paper if needed.)*

Was this a motor vehicle accident? ☐ Yes *(Attach the police report.)* ☐ No

Was the patient involved in any other type of accident that required a police report? ☐ Yes *(Attach the police report.)* ☐ No

Did the accident occur at work? ☐ Yes *(Attach a copy of report of the injury filed with your employer.)* ☐ No

Primary Care Provider Information

First name	Middle initial	Last name

Address - Street	City	State	Zip code

Phone number

Please provide the following information for all doctors and hospitals that have treated you for your accident/injury

Physician/Provider/ Facility name	Phone number

Address - Street	City	State	Zip code

Dates consulted

If applicable, date of hospital admission *(mm/dd/yyyy)*	Hospital discharge date *(mm/dd/yyyy)*

Physician/Provider/ Facility name	Phone number

Address - Street	City	State	Zip code

Dates consulted

If applicable, date of hospital admission *(mm/dd/yyyy)*	Hospital discharge date *(mm/dd/yyyy)*

SECTION 4: Additional Details

Was a Ground Ambulance service used? ☐ Yes ☐ No

If Yes, provide the date ground ambulance transportation occurred, billing invoices, and all supporting documentation for receipt of this service. *(mm/dd/yyyy)*

Was an Air Ambulance service used? ☐ Yes ☐ No

If Yes, provide the date air ambulance transportation occurred, billing invoices, and all supporting documentation for receipt of this service. *(mm/dd/yyyy)*

If applicable, did the patient's companion stay at a lodging that meets the Lodging Benefit requirements?

☐ Yes ☐ No

If Yes, provide the lodging checkout receipt. *(mm/dd/yyyy)*

SECTION 5: Special Payment Instructions & Direct Deposits

- If you would like claim benefits paid using direct deposit, please provide the information requested for the bank where you have your account.
- The sample check below may help you locate your bank account and bank routing numbers. Please be sure that you are referencing one of your checks, not a deposit or withdrawal slip.

- If a savings account is used, please check with your bank representative for the appropriate routing and account numbers.
- Use the space below if you need to provide any special instructions. *(e.g., requesting that your claim proceeds be sent to an address other than the address of record).*

Would you like claim benefit payments paid using direct deposit?

☐ Yes ☐ No *(If Yes complete the Account Information section below.)*

Bank name	Bank telephone number

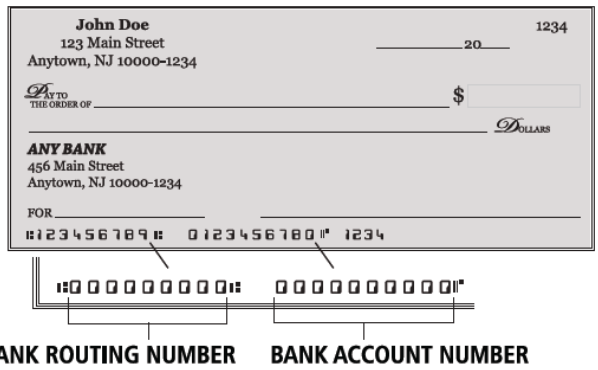
Bank street address	City	State	Zip code

Type of account *(check one):* ☐ Checking ☐ Savings

Be sure to confirm your account and routing numbers with your bank to ensure prompt processing.

Bank routing number

Bank account number



Authorization & Signature of Certificateholder

- I request MetLife to send my payments to the financial institution designated in Section 5 for deposit into my account. This agreement will remain in effect until MetLife receives notice from me to the contrary.
- I understand that MetLife will not be liable for any failure to change or terminate this agreement until a written request is received from me in satisfactory form and reasonable time has passed for MetLife to act upon it.
- If any overpayment is credited to my account in error, I authorize and direct my financial institution to debit my account and to refund such overpayment to MetLife.

Name *(Please print)*

Sign Here Certificateholder Signature

Date *(mm/dd/yyyy)*

Next steps:

- Review and complete the Fraud Warnings, Certification & Signature sections.
- Review and complete the Authorization to Disclose Health Information Page.

MetLife

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, 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: 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 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.

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.

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.

SECTION 6: Certification & 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/social security 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.

Sign Here Signature of Insured or Authorized Representative | Date *(mm/dd/yyyy)*

Name of Insured or Authorized Representative, if applicable *(Please print)*

First name	Middle initial	Last name

If signed by Authorized Representative, describe your authority and provide documentation.

(e.g., guardian, conservator, power of attorney, etc.)

SECTION 7: How To Submit This Form

Please return completed and signed form by fax, mail or on-line.

Mail:
Attn: Group Hospital Indemnity Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Telephone:
1 866 626 3705

Fax:
1 855 306 7350

E-mail:
https://mybenefits.metlife.com

Authorization to Disclose Health Information

Metropolitan Life Insurance Company

Things To Know Before You Begin

- **Instructions for completing the form: complete all applicable areas of the form and sign below.**
- **If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.**

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

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).

For purposes of determining my eligibility for accident benefits, the administration of my accident benefit plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for accident 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 accident 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 accident 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 accident claim.

This Authorization to Disclose Health Information 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 Group Accident at P.O. Box 80826, Lincoln, NE 68501-0826, 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.

Name of Patient or Authorized Representative *(Please print)*

First name	Middle initial	Last name	Date of birth *(mm/dd/yyyy)*

Sign Here Signature of Patient or Authorized Representative | Date *(mm/dd/yyyy)*

If signed by Authorized Representative, describe your authority and provide documentation.

(e.g., guardian, conservator, power of attorney, etc.)

How To Submit This Form

Mail:
Attn: Group Hospital Indemnity Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Telephone:
1 866 626 3705

Fax:
1 855 306 7350

E-mail:
https://mybenefits.metlife.com