MetLife

Critical illness and cancer insurance claim form

Metropolitan Life Insurance Company

Please return completed and signed form by fax, mail or on-line. Complete Section 1 on the Physician's Statement. Your physician must complete the remainder of the Physician's Statement *(all of Section 2)* and return the completed form to MetLife.

Important instructions for requesting critical illness and/or cancer benefits

- If this is an Initial Claim for an illness, please complete each section in its entirety. *(An illness is not considered reported to us until a claim form is received).*
- If this is an additional claim for an illness previously reported *(i.e. - initial claim previously submitted and additional services were incurred)*, no claim form is required. Please provide supporting documentation from the healthcare provider related to the critical illness for which a claim is being made.
- Include your claim number and/or certificate number on all pages of your submission.
- Please provide us with supporting documentation from the healthcare provider(s) related to the Critical Illness for which a claim is being made. The supporting documents MUST include 1) the diagnosis, 2) the date(s) of diagnosis, and 3) pathology reports, surgical notes, UB 04 forms, lab results, or medical records that support the diagnosis of the covered condition.
- Examples of medical documentation and information needed based on the patient's condition:

If your claim is for any of these conditions	Please include the following medical information with your claim
Full Cancer	Pathology Reports, Surgical Reports, TNM Stage Classification
Partial Cancer	Pathology Reports, Surgical Reports, TNM Stage Classification
All Cancer Types	Office notes/medical records that show observation of signs, symptoms and tests that confirm the diagnosis
Coronary Artery Bypass Surgery	Open heart surgical reports and documentation showing diagnostic need for surgery
End Stage Kidney Failure	Kidney Specialist records or dialysis records
Heart Attack	Hospital Summary, EKGs, Cardiac Enzymes. If completed, provide any of the following: Thallium Scans, Muga Scans, Stress echocardiogram, Cardiac Catheterization Report
Bone Marrow, Heart Transplant 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

- If the patient is deceased, we will need a copy of the death certificate.
- You must sign and submit the attached **Authorization to Disclose Health Information.**

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. Please refer to your certificate of insurance for a listing of specific benefits covered under your plan.

SECTION 1: Certificateholder information *(Supply information about the certificateholder)*

Certificateholder name

First name	Middle initial	Last name	
Address	City	State	ZIP code
Certificate number	Date of birth *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female	Social Security number
Cell phone number	Daytime phone number	Evening phone number	
Email address *(optional)*	Employer name		

SECTION 2: Patient information *(Supply information about the patient.)*

☐ 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 name	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: What type of condition are you claiming?

- Please provide us with the covered condition for which you are filing a claim. Refer to your group certificate of insurance or Summary Plan Description for a complete description of your benefits.

Describe condition ______________________________

On what date were you first seen for this condition? *(mm/dd/yyyy)* ______________________________

Name of physician who diagnosed your condition

First name	Middle initial	Last name	
Physician address	City	State	ZIP code

Confirmed diagnosis date *(mm/dd/yyyy)* ______________________________

Have you ever been treated for a same or similar condition in the past? ☐ Yes ☐ No

If "Yes", when? Please provide details.

If the claimant is deceased, check here ☐ and provide a copy of the following information:

- Death certificate
- Medical records that document the claimant's covered condition
- Autopsy report *(if available)*

SECTION 4: 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.)

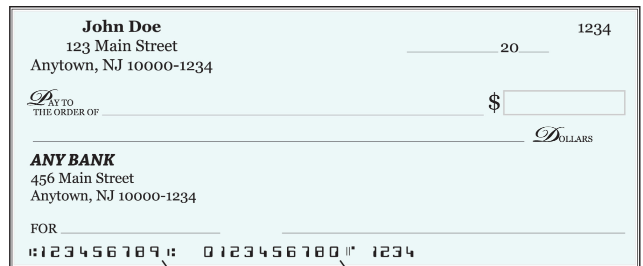
Bank name			Bank telephone number
Bank address - street	**City**	**State**	**ZIP code**

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 4 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)*

First name	Middle name	Last name

Sign Here Signature of Certificateholder ______________________ Date *(mm/dd/yyyy)* __________