

# Disability Paper Claim Form Guide

This guide provides helpful instructions on how to complete a MetLife Disability paper claim form.

## Section 1: To be Completed by your Employer.

It's important that the employer participates in the claim filing process.

To speed up processing, the employer must complete this section of the claim form. If not, MetLife will send it to the employer, and they will have 10 business days to complete and return it.

- Group Report, Sub-Code Number and Sub-Point Number: Please contact your MetLife service team, if you don't have this information. Please note: Leaving this blank may slow down claim processing.
- Address: Please provide the employer address that was originally given when the policy was issued with MetLife.
- Contact Person Information: Enter the contact person who can answer questions regarding the company's benefit program and employee's employment details.
- Supervisor Information: Enter the employee's direct supervisor's contact information.

Disability Claims



## Accident & Sickness (A&S)/Short Term Disability (STD)/Salary Continuance

Metropolitan Life Insurance Company

### Things to Know Before You Begin

- Complete all applicable areas of this form that apply to you (Employer, Employee and Physician/Provider) Please print clearly.
- Your signature is required at the end of your section: Employer see SECTION 1, Employee see SECTION 2, and Physician/Provider see SECTION 3.

**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.

### SECTION 1: To Be Completed by the Employer

Employer Name		Subsidiary or Division Name	
Group Report Number	Sub-Code Number (Sub-Division)	Sub-Point Number (Branch)	

Address	City	State	ZIP
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We require a street address for our records if a P.O. Box is your mailing address

### Contact Person Information

Contact's First Name		Last Name	
Phone Number	Fax Number	Email	

### Supervisor Information

Supervisor First Name		Last Name	
Phone Number	E-Mail		

### Section 1: To be Completed by your Employer, continued...

- Job Class: Check one box that best describes the category of the employee's job requirements. The employee moves objects up to:
  - Sedentary: 10 lbs. (pounds) occasionally.
  - Light: 10 – 20 lbs. occasionally
  - Medium: 20 – 50 lbs. occasionally.
  - Heavy: 50 – 100 lbs. occasionally. and/or 25 – 50 lbs. frequently.
  - Very Heavy: More than 100 lbs. occasionally and/or 50 lbs.+ frequently.
- Premium Contributions, Benefit Amount and Payroll Classification: Please reach out to your HR Benefits and/or Payroll department to obtain this information. This is critical to tax benefit calculations.
- To the best of your knowledge, indicate if the employee has filed for or is receiving income from any of the income sources listed: Please review this section with your employee and check the box for each type of paid leave benefit the employee has applied for and/or will be receiving, including other paid leave (i.e., vacations). Also, provide the dollar amount, how often the employee expects to receive the paid benefit (frequency) and timeframe (from and to date).
- Provide weekly deduction amounts (if applicable) : Please locate the employee's paycheck and provide the payroll deductions amounts for each federal, state, and company withholdings, pre- and post-tax.

#### Employee Information

First Name		Middle Name		Last Name		
Social Security Number		Employee ID Number (if applicable)		Date of Hire (mm/dd/yyyy)		
Job Title			Work Phone Number			
Job Class <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy			Home Phone Number			
Work Location Address			City	State	ZIP	
Is condition work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, provide: _____						
Workers' Comp (WC) Carrier		Workers' Comp Claim Number		W/C Contact Person's Phone Number		
W/C Contact Person - First Name			Last Name			
Date Last Worked (mm/dd/yyyy)	First Date of Absence (mm/dd/yyyy)	Date Returned To Work (mm/dd/yyyy)	<input type="checkbox"/> Actual <input type="checkbox"/> Estimated	Eff. Date of Coverage (mm/dd/yyyy)		
Basic Earnings (exclusive of overtime, bonus, etc.) \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual						
Premium contributions <input type="checkbox"/> Pre-Tax <input type="checkbox"/> Post-Tax		Benefit Amount	Payroll Classification			
Employer _____ %	Employee _____ %		<input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	<input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Other _____		
Employee's Status as of First Day of Absence						
<input type="checkbox"/> Active <input type="checkbox"/> Vacation <input type="checkbox"/> LOA <input type="checkbox"/> Laid Off <input type="checkbox"/> Terminated <input type="checkbox"/> Retired						
If other than Active, please explain _____						
Hours Worked Per Week		Work Week				
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	<input type="checkbox"/> Regular <input type="checkbox"/> Variable					
Scheduled Work Week <input type="checkbox"/> M <input type="checkbox"/> Tu <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F <input type="checkbox"/> Sa <input type="checkbox"/> Su						
If STD buy up, date enrollment card signed (mm/dd/yyyy)		LTD Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has return to work been discussed with employee? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Can employee's job be modified/accommodated? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please describe. _____						
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 Date	To Date
Salary Continuance/Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>				
COVID 19 Paid Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>				
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>				
State Disability	<input type="checkbox"/>	<input type="checkbox"/>				
Other (please identify)	<input type="checkbox"/>	<input type="checkbox"/>				
Provide weekly deduction amounts, if applicable:						
	Pre Tax	Post Tax	\$ Weekly Amount			
Medical	<input type="checkbox"/>	<input type="checkbox"/>				
Life	<input type="checkbox"/>	<input type="checkbox"/>				
Dental	<input type="checkbox"/>	<input type="checkbox"/>				
LTD	<input type="checkbox"/>	<input type="checkbox"/>				
Other (please identify)	<input type="checkbox"/>	<input type="checkbox"/>				
<b>Sign Here</b>	Authorizing Employer Signature				Date (mm/dd/yyyy)	



This is an official document; the employer must sign and date this section of the claim form.

## Section 2: To be Completed by Employee.

- Federal Tax Status and Tax Exemptions:**

Check the appropriate box to describe your federal tax status and provide the number of tax exemptions. This is critical to accurate calculation of taxes.

- Provide Details:** Please provide any additional details related to your claim. If your claim is due to pregnancy/maternity, please provide your expected delivery date and delivery type (Vaginal or Cesarean).

- Is this condition work-related?:** Please confirm if your condition is work-related. If yes, you will need to provide MetLife with your workers compensation statement.

- Name the physicians/providers who have treated you for this condition in the past 12 months:** Provide the contact information of the health care provider(s) treating you for your condition, including those who have advised you to stop/limit working. Example: If you undergo surgery, please provide us with contact information of your main treating physician (who diagnosed you), your surgeon, as well as treatment dates including date of surgery or hospitalization date(s).

- Please describe what prevents you from performing the duties of your job:** Describe how your condition is preventing you from performing the duties of your job. Example: Having surgery may result in physical limitations (i.e., inability to walk/type/lift/etc.) for 4-6 weeks.

## SECTION 2: To Be Completed by Employee

Some services in connection with your Disability Claim may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

First Name	Middle Name	Last Name	
Social Security Number	Employee ID number (if applicable)	Date of Birth (mm/dd/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address	City	State	ZIP
We require a street address for our records if a P.O. Box is your mailing address			Email
Home Phone Number	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	Federal Tax Status <input type="checkbox"/> Married <input type="checkbox"/> Single	Tax Exemptions (Number)
Date Disability Began (mm/dd/yyyy)	Is your disability due to <input type="checkbox"/> Illness? <input type="checkbox"/> Injury/Accident? If due to injury/accident, provide	Date (mm/dd/yyyy)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM

Provide Details (Where and How)

Is this condition work-related?  Yes  No      Automobile-related?  Yes  No

Name of physicians/providers who have treated you for this condition within the past 12 months

Name of Physician/Provider	Phone Number	Dates of Treatment: From	Dates of Treatment: To	Physician/Provider Specialty

Please describe what prevents you from performing the duties of your job.

**Sign Here** Employee Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_



This is an official document; the employee must sign and date this section of the claim form.



Reminder: Please ensure you complete the Authorization to Disclose Information About Me at the end of the claim form.

**Section 3: To be Completed by Attending Physician/ Provider.**

- Primary and Secondary ICD-10 Diagnosis Code and Diagnosis Name: Provide the Primary ICD-10 Diagnosis Code and Diagnosis Name. If applicable, provide the Secondary ICD-10 Diagnosis Code and Diagnosis Name.
- Objective Findings: Summarize your objective findings (to include test results, imaging studies, observed behaviors, functionality, etc.) that would assist us in evaluating the patient's claim for disability benefits.
- CPT4, Procedure and Date: If your patient will undergo a medical procedure, provide the CPT4 procedure code, description and date of the procedure.
- Delivery Date: If the patient is pregnant, please provide the delivery date or the expected date along with the delivery type (Vaginal or Cesarean).
- Treatment Plan: Select the box(es) that best defines your patient's treatment plan.
- Medications Prescribed: List current medications prescribed including dosages. Also, please include any discontinued medications, and dosages.
- Contact information (blue box): Provide contact information in case MetLife needs to contact you directly for additional information.

**SECTION 3: To Be Completed by Attending Physician/Provider**

This report is to assist us in making a disability determination that impacts income replacement for your patient. A MetLife claim representative may telephone your office if additional information is needed.

Patient First Name		Middle Name	Last Name
Date Disability Began (mm/dd/yyyy)	Expected Return to Work Date (mm/dd/yyyy)	Initial date of treatment for this disability (mm/dd/yyyy)	Most recent date of treatment (mm/dd/yyyy)

Is this condition work related?  Yes  No

Primary Diagnosis Code	Diagnosis		
Secondary Diagnosis Code	Diagnosis		
Objective Findings			
CPT4	Procedure	Date (mm/dd/yyyy)	
If pregnancy, delivery date (mm/dd/yyyy)	<input type="checkbox"/> Expected (mm/dd/yyyy)	<input type="checkbox"/> Actual (mm/dd/yyyy)	Type of delivery
If patient has been hospitalized <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	Admitted (mm/dd/yyyy)	Discharged (mm/dd/yyyy)	

Treatment Plan:	<input type="checkbox"/> Additional Testing	<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Surgery	<input type="checkbox"/> Hospitalization
	<input type="checkbox"/> Referral	<input type="checkbox"/> Other (Describe)			
Medications prescribed (names, dosages)					

Is patient able to work with job modifications or restrictions? (please be specific)

Physician/Provider Specialty		E-mail			
Address		City	State	ZIP	
Tax ID Number	Phone Number		Fax Number		
<b>Sign Here</b>	Signature of Physician/Provider			Date (mm/dd/yyyy)	



The physician/provider must sign and date the APS statement. If your signature is missing, this may delay your patient's claim processing.



## How to submit your paper claim form:

The **How to submit the form** section on the last page provides the mailing address or fax number to send your completed claim form to us.



### SECTION 4: How to Submit This Form

**Mail:**

MetLife Disability  
PO Box 14590  
Lexington KY 40512-4590

**Fax:**

1-800-230-9531

## What happens after I submit my claim form?

- Please ensure you complete the Authorization to Disclose Information About Me at the end of the claim form.
- Within 2-4 business days of filing your claim with MetLife, you will receive an Acknowledgement Package with important information regarding your claim(s).
- A MetLife claims specialist may contact you for additional details about you, your job, your condition, your treatment plan and provider. Your claims specialist will also discuss your estimated return to work date.
- Employers will be contacted to confirm employment and coordinate other eligible benefits.
- We'll follow up with a letter detailing any missing information to complete your claim, if needed.
- MetLife will make a decision about your claim.
- Once a decision is made on your claim(s), you'll receive a letter outlining next steps and instructions on how to contact MetLife if you require further assistance.