GROUP LIFE INSURANCE STATEMENT OF REVIEW

MetLife®
Metropolitan Life Insurance Company
P.O. Box 14632
Lexington, KY 40512-4632
Phone: 1-800-243-8786

Please check all appropriate boxes for this submission

☐ **Continued Protection (Premium Waiver During Total Disability)**
☐ **Continued Life Insurance During Total Disability**

EMPLOYER'S STATEMENT

Section 1: Employer Information

Important: If MetLife does not maintain your Group Life records, please attach all enrollment forms, beneficiary designation, and any other forms in the life insurance file.

Employer Name	Name of Group Policyholder if different than the Employer		
Address of Employer or Group Policyholder	City	State	Zip Code
Address of Group Policyholder if different than the Employer	City	State	Zip Code
Contact Person's Name	Phone #	Fax #	E-mail Address

Section 2: Employee Information

Name (Last, First, MI)	Social Security # - **REQUIRED**	Date of Birth (MM/DD/YY)		
Address	City	State	Zip Code	
Claimant's Occupation/Job Title (Attach a job description)	Date of Hire	☐ Salaried ☐ Hourly	Base Wages as of Last Date Worked $__________ ☐ Hourly ☐ Weekly ☐ Monthly	Number of hours worked per week: __________

Section 3: Coverage Information

Date Last Worked?	Why did employee cease work on that date?

Coverage	**Report Number**	**Sub Code Number**	**Branch Number**	**Employee Life Insurance Effective Date**	**Amount of Insurance**	**Date Insurance Amount Last Changed**	**Cancellation Date (if any)**	**Premium Payments Terminated? (Yes/No)**	**Has Policy converted to an Individual Policy? (Yes/No)**
Basic Life									
Optional Life									

Does your Company Provide Retirement Benefits? ☐ Yes ☐ No If "Yes," please answer these questions:	Check Type of Benefit: ☐ Normal ☐ Disability Would the Employee Qualify? ☐ Yes ☐ No Date on which Employee would qualify?__________

Employer's Authorized Representative

Name (Please Print) __________ Title: __________ Phone # __________

Signature: __________ Date: __________

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EMPLOYEE'S STATEMENT

Instructions for completing form:

1. **The employee or his/her legal representative must complete statement. If you are an Authorized Representative completing this form, please include a copy of the legal document(s) authorizing you to act on the Employee's behalf.**
2. **Complete Sections 1 & 2 and sign applicable pages as indicated.**
3. **Contact MetLife with any questions you may have when completing this form.**
4. **Submit the entire form by mail to the above address for processing – retain a copy for your records.**

Important: **To avoid processing delays, please complete the form in its entirety and submit all requested Documents.**

Section 1: Personal Information

Name (Last, First, MI)	Social Security # **REQUIRED**	E-Mail Address (Optional)

Address	City	State	Zip Code	Date of Birth (MM/DD/YY)	Sex ☐ M ☐ F

Home Phone # ( ) -	Occupation	Marital Status ☐ Married ☐ Single ☐ Other

Section 2: Disability Information

Date Last Worked	State the cause of your Disability:	On what date were you first treated by a physician related to this disability?

Name(s) of all Physicians/Providers who have treated you since the beginning of this disability:

Name of Physician/Provider	Address	Phone Number (Include Area Code)	Dates of Treatment	Reason for Visit

Have you performed any type of work (either for this employer, another employer or through self-employment) since your disability began? ☐ Yes ☐ No
If "Yes," provide the following information:

Name of Employer	**Address of Employer**	**Type of Work**	**Date Employment Began**	**Hours Worked Per Week**

Are you presently able to engage in any gainful occupation? ☐ Yes ☐ No

If "Yes," please explain: ____________________

If "No," when do you expect to return to work? Date ____________________

Are you insured under any other policies issued by MetLife? ☐ Yes ☐ No

If "Yes," please provide coverage type and policy numbers: ____________________

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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).

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's life plan.

Name of Claimant (Please Print) ______________________

Social Security Number ________-_________-__________

Authorization to Disclose Information About Me

For purposes of determining my eligibility for continued life insurance coverage due to a disability or for the total and permanent disability benefit under the administration of my employer's life benefit plan, as the case may be, 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 life 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 disability claim.
2. **I permit** MetLife to disclose to my employer in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and disability 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 at P.O. Box 14632, Lexington, KY 40512-4632, 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 ______________________

ATTENDING PHYSICIAN STATEMENT

MetLife®
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P.O. Box 14632
Lexington, KY 40512-4632

Instructions for completing the form:

Employee:
1. **Please complete and sign Section A. Any fee for the completion of this form is the patient's responsibility.**

Attending Physician:
2. **Please complete Section B and all remaining applicable areas and sign form.**
3. **Mail form to the above address.**

Section A

Occupation

Name	Social Security # **Required**	Employer	Group Report #

I hereby authorize my physician to release any information acquired in the course of my examination or treatment.

Date of Birth

Signature of Employee ______________________________ Date ______________

Section B

The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form.
A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: ☐ Injury ☐ Illness

Is condition work-related? ☐ Yes ☐ No

Initial date of treatment ______________________

Most recent date of treatment ______________________

Did you advise the patient to cease the above noted occupation? ☐ Yes ☐ No If Yes, Date ______________

Names and Phone Numbers of the other providers the patient was referred to:

Name	Phone #	Name	Phone #

Has patient been hospitalized? ☐ Yes ☐ No If Yes, Date Confined ______________ Through ______________

Name and address of facility:

Diagnosis and Treatment

Primary ICD-9 _____ . __________ Diagnosis ______________________________

Secondary ICD-9 _____ . __________ Diagnosis ______________________________

Subjective Symptoms

Objective Findings (Include copies/results of any x-rays, lab tests', EKG's, MRI's, scans and office notes)

Current and Recommended Treatment Plans ______________________________

If surgery performed/anticipated, provide the following:

CPT-4 ______________________ Procedure ______________________ Date ______________

Medications prescribed (names, dosages)

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Name of Employee: ______________________ **Social Security Number:** ______________

Psychological Functions – Check applicable box below

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

What stress factors or problems with interpersonal skills have affected patient's ability to perform the duties of his or her job?

Is patient competent to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

Physical Capabilities:

(a) Patient's ability to: (circle)

	Hours	(check)	
Sit	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Stand	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Walk	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently

(b) Patient's ability to: (circle)

Climb	Yes	No
Twist/bend/stoop	Yes	No
Reach above shoulder level	Yes	No
Operate a motor vehicle	Yes	No

(c) Patient's ability to lift/carry: (check)

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67%-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐
Over 100 lbs.	☐	☐	☐	☐

(d) Patient's ability to perform repetitively: (circle)

	Right Hand		Left Hand	
Fine finger movements	Yes	No	Yes	No
Eye/hand movements	Yes	No	Yes	No
Pushing/pulling	Yes	No	Yes	No
Dominant hand	R________		L________	

(e) In your opinion, why is patient unable to perform job duties?

(f) Patient can work a total of ______________ hours per day?

(g) Do you expect improvement in any area?
(If so please comment and give dates/timeframes.)

Cardiac:

Functional Capacity (American Heart Association) Complete only if applicable.

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Blood pressure (latest reading) __________/__________ as of (date) __________/__________

Is patient in a cardiac rehabilitation program?

Extent of Disability

	For Any Occupation	For His/Her Regular Occupation
(a) Is Patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If no, when was patient able to go to work?	Mo. ______ Day ______ Yr. ______	Mo. ______ Day ______ Yr. ______
(c) If yes, when do you think patient will be able to resume any work?		
Approximate Date:	Mo. ______ Day ______ Yr. ______	Mo. ______ Day ______ Yr. ______
Indefinite:	☐	☐
Never:	☐	☐

Rehab:

Do you suggest that the patient become involved in any of the following? Please check as many as apply.

If so, was this discussed with the patient? ☐ Yes ☐ No

☐ Physical Therapy ☐ Pain Management Program ☐ Vocational Rehabilitation
☐ Occupational Therapy ☐ Work Hardening Program ☐ Psychological Counseling
☐ Cardiac Rehabilitation ☐ Job Modification ☐ Other ______________

Physician:

Name ______________________ Degree/Specialty ______________

Street Address ______________________ City ______________ State ______ Zip Code ______

Telephone # (____) ______________ Fax # (____) ______________ Tax ID # ______________

Contact person if additional information is necessary ______________________

Signature ______________________ Date ______________

FRAUD WARNINGS

If the insured was covered under a policy issued in one of the states listed below, **or** if you reside in one of the states listed below, one of the following state warnings may apply to you:

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.

Alaska, Delaware, Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Arkansas, Louisiana, New Mexico: 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 civil fines and criminal penalties.

California: 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 life insurance, and civil damages. It is also unlawful for 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 respect to a settlement or award payable from insurance proceeds. Such acts shall be reported to the Colorado Division of Insurance with the Department of Regulatory Agencies to the extent required by applicable law.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim 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.

Indiana, Minnesota, 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: A person who, with 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 is guilty of insurance fraud.

Oklahoma: 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.

Pennsylvania: 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

If the insured was covered under a policy issued in any state other than those listed above, **or** if you reside in any state other than those listed above, then the following warning may apply to you:

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 may be a crime and may subject such person to criminal and civil penalties.