MetLife

Hospital Indemnity Insurance Claim Form

Metropolitan Life Insurance Company

Important Instructions for Requesting Hospital Indemnity Benefits

- Complete each section in its entirety.
- You must sign and submit the **Authorization to Disclose Health Information** form *(attached)*.
- For a listing of specific benefits covered under your plan, please refer to your certificate of insurance.
- Provide supporting documentation for the related services for which a claim is being made. The supporting documents MUST include:
  - Claimant/Patient's name
  - Admission & discharge dates from treating hospital or rehab facility to include room assignment type *(ICU and or Non-ICU)*
  - Diagnosis, treatment details and discharge papers regarding your emergency room visit, or urgent care visit and/or hospital stay
  - If treatment is due to an auto-accident, provide a copy of the police report, toxicology or if a blood screening was completed
  - Please request a UB-04 form from the billing department of the treating hospital which outlines all the services provided to you during your hospital stay. This is the best document to submit to maximize benefits available under your plan
  - If the Claimant/Patient is deceased, we will need a copy of the death certificate

Failure to complete all sections of this claim form will delay processing of your claim.

Be sure to provide all documentation as outlined above 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 *(Employee)*

First Name	Middle Initial	Last Name

Address - Street	City	State	Zip Code

Certificate Number	Date of Birth *(mm/dd/yyyy)*	Social Security Number

Gender	Phone Number	Email Address
☐ Male ☐ Female ☐ Gender X		

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

First Name	Middle Initial	Last Name

Home Address - Street	City	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	Gender	Social Security Number
	☐ Male ☐ Female ☐ Gender X	

Phone Number

_____

SECTION 3: Hospitalization Details

Refer to your group certificate or Summary Plan Description for a complete description of your benefits. Not all plans contain the same benefits.

For items within Section 3, provide required documentation noted on page 1 Important Instructions

Please explain why you were hospitalized

Admission Date *(mm/dd/yyyy)*	Discharge Date *(mm/dd/yyyy)*

Hospital Name

City	State

Are you claiming for Hospital Benefits? ☐ Yes ☐ No

Are you claiming for Surgery Benefits? ☐ Yes ☐ No

Are you claiming for Additional Care Benefits? ☐ Yes ☐ No

Are you claiming for Other Benefits? ☐ Yes ☐ No

In addition to required documentation, provide any additional details of all services received for which you are submitting this claim:

SECTION 4: Special Payment Instructions & Direct Deposits

- If you would like to 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

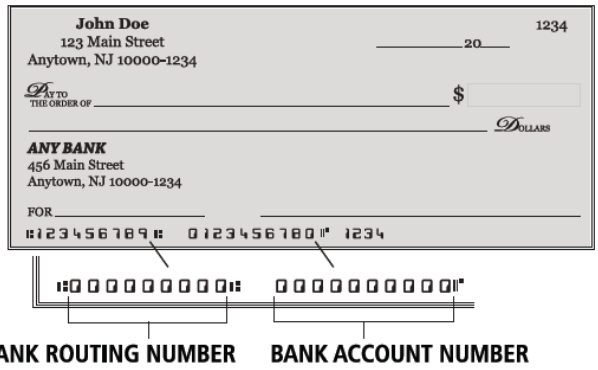
Bank Street Address	City	State	Zip Code

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 *(Employee)*

- 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)*

Sign Here Signature of Certificateholder | 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

State Specific Fraud Warnings – Group Product Claim Forms

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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.

Delaware: 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.

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.

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.

Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

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.

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.

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.

SECTION 5: 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 Certificate Holder 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 6: How to Submit This Form

Return completed and signed form on-line, mail, or email.
The email address provided is for submitting medical and claim information only. All questions and inquiries should be directed to the toll-free number provided.

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

Telephone:
1 866 626 3705

E-mail:
ahmetlifeclaims@metlife.com

Online:
https://mybenefits.metlife.com

Authorization to Disclose Health Information

Things to Know Before You Begin

- Instructions for completing the form: The Claimant completes all applicable areas of the form and signs 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 hospital indemnity 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 hospital indemnity benefits, the administration of my hospital indemnity benefit plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for hospital indemnity 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 hospital indemnity 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 hospital indemnity 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 hospital indemnity 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 Claimant or Authorized Representative

First Name *(Please print)*	Middle Initial	Last Name

Date of Birth *(mm/dd/yyyy)*	Social Security Number

Sign Here Signature of Claimant 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:
Metropolitan Life Insurance Company
Attn: Group Hospital Indemnity Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Telephone:
1 866 626 3705

E-mail:
ahmetlifeclaims@metlife.com

Online:
https://mybenefits.metlife.com