PART 1

Group Accident Insurance Claim Form

MetLife

Things to know before you begin

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- [illegible]
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[illegible]
[illegible] 80826
[illegible], NE 68501-0826
[illegible]: 1 866 626 3705
[illegible]: 1 855 306 7350
[illegible]

[illegible] 5 [illegible] 6. [illegible]

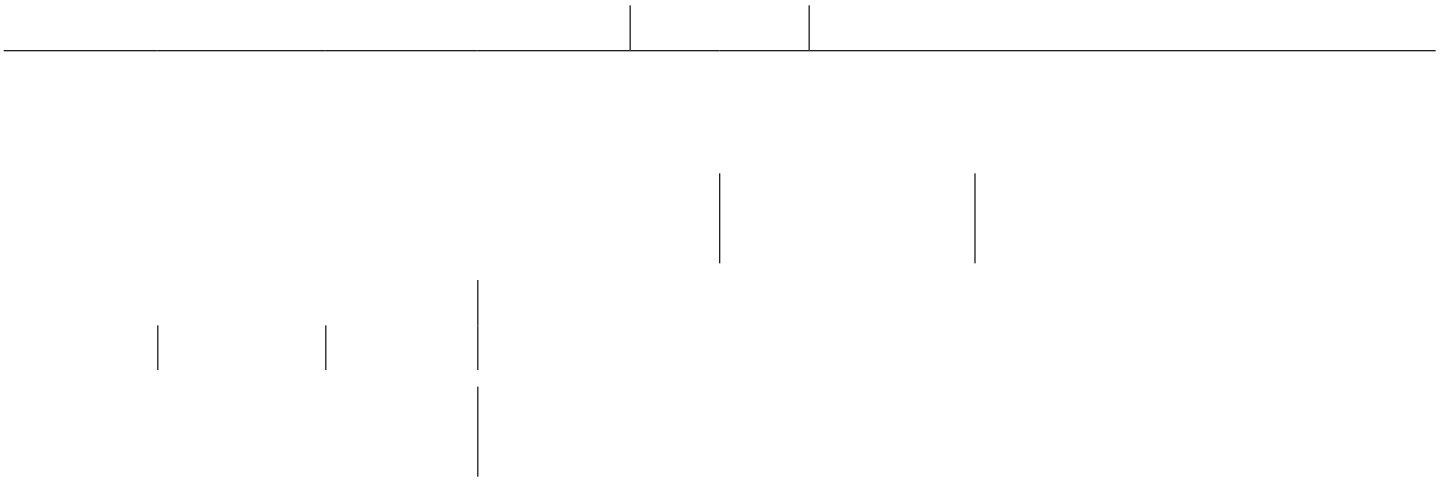
[illegible]

Supply information about the certificateholder.

SECTION A: Certificateholder Information

Certificateholder Name *(First, Middle Initial, Last Name)*		Certificate Number
Address - Street		
City	State	Zip Code
Date of Birth *(Month/Day/Year)*	Gender ☐ Male ☐ Female	Social Security Number
Cell Phone Number	Daytime Phone Number	Evening Phone Number
EMAIL Address *(optional)*	Employer Name	

SECTION B: Patient Information



Answer the questions in this section and follow the next steps.

SECTION D: Checklist

Did you complete Section A, Section B and Section C? ☐ Yes ☐ No *(If No, please explain.)*

Did the patient require Ground Ambulance? ☐ Yes ☐ No *(If Yes, provide the date ground ambulance transportation occurred.)*

(Ground Ambulance means a licensed professional ambulance service was required to transport a covered person by ground to or from a hospital or between medical facilities where treatment for an injury is received.)

(Month/Day/Year)

Did the patient require Air Ambulance? ☐ Yes ☐ No *(If Yes, provide the date air ambulance transportation occurred.)*

(Air Ambulance means a licensed professional air ambulance service was required to transport a covered person by air to or from a hospital or between medical facilities where treatment for an injury is received.)

(Month/Day/Year)

Does the patient's companion meet the Lodging Benefit requirements? ☐ Yes ☐ No *(If Yes, provide the date ground ambulance transportation occurred.)*

(Lodging Benefit means the patient is confined in a Hospital for treatment of an Injury and a companion who accompanies the patient while the patient is confined stays in lodging for which a charge is made. Proof that the companion incurred an expense for staying in lodging should be submitted)

(Month/Day/Year)

SECTION E: Special Payment Instructions & Direct Deposits

- If you would like claim benefts 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

Fraud Warnings *(c i ed)*

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person les 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, Virginia 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, nes or a denial of insurance bene ts.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or bene t or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to nes and con nement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, les a statement of claim containing false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.

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

Oregon and Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal o ense and 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 les, assists or abets in the ling of a fraudulent claim to obtain payment of a loss or other bene t, or les 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 ne of no less than ve thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a xed term of three (3) years, or both. If aggravating circumstances exist, the xed jail term may be increased to a maximum of ve (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 nes and con nement in state prison.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person les 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.

By signing belownn6 16.75 m8(u)6ji:(o)10(n w)9(ho)6(e65(f)(1.10Spans(1 p).361 0SQ1 b 1 01 31JxEFF08BDC (q 1E0Mo d mTd0

Physician's Attachment

Group Accident Claim – Physician Statement

MetLife

Things to know before you begin

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- A
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-
- I 1 866 626 3705.

Att: G A
B 80826
L , NE 68501-0826
F : 1 866 626 3705
F N : 1 855 306 7350

The patient must complete this section.

SECTION 1: About the Patient

Patient name *(First, Middle Initial, Last Name)*

SECTION 3: Burn *(Percentage of total surface skin area that is affected by the burn)* Check the Box that applies.

2nd Degree Burn: ☐ Less than 10% ☐ At least 10% but less than 25% ☐ At least 25% but less than 35% ☐ 35% or more

3rd Degree Burn: ☐ Less than 10% ☐ At least 10% but less than 25% ☐ At least 25% but less than 35% ☐ 35% or more

Was a skin graft performed as a result of the burns? ☐ Yes ☐ No

SECTION 4: Fracture

Nature of Surgical Procedure, if any. *(Describe fully and give approach used even if more than one is used.)*

SECTION 7: Accidental Dismemberment, Accidental Functional Loss & Paralysis

F [redacted]:

- L [redacted]: [redacted], [redacted].
- L [redacted]: [redacted] 20/200 [redacted] 20 [redacted].
- L [redacted]: [redacted], [redacted].

[redacted]:

- [redacted].

Please select the condition your patient has and provide details at the bottom of the page:

☐ Loss of hearing

☐ Loss of sight

☐ Loss of ability to speak

☐ Paralysis

☐ Dismemberment

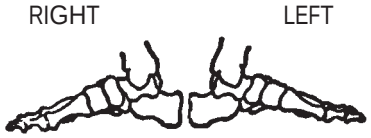
1. For a dismemberment, which limb/digit was severed or amputated?

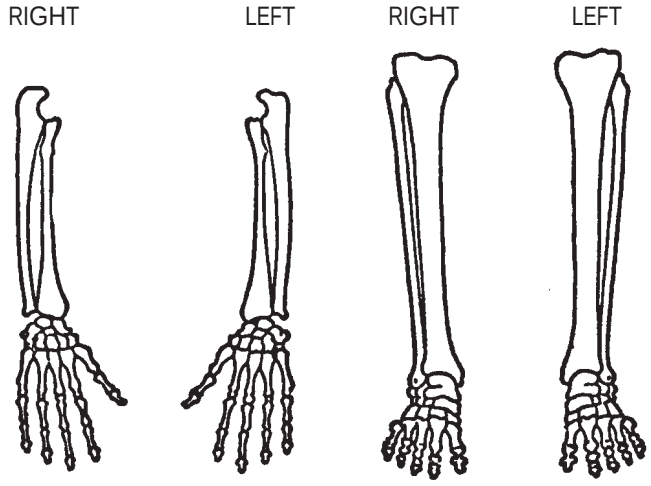
2. For a functional loss or paralysis please describe where the loss has occurred.

3. State the dates on which the severance or amputation, functional loss or paralysis occurred.

4. State the cause of the severance/amputation/functional loss/paralysis.

5. If a limb/digit was reattached, indicate date of reattachment and functional outcome.





State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.

The Physician must complete all of Section 8.

SECTION 8: Treatment History

[redacted]

1. Date of accident resulting in injury(ies) for which you were consulted. *(Month/Day/Year)*

2. The date(s) your patient first consulted you for injury(ies) resulting from the accident.

3. Date of last treatment for the injury(ies) *(Month/Day/Year)*

4. Describe the exact nature, location, and extent of all injuries sustained.
(If additional space is needed, attach a separate sheet.)

5. Was the accident reported in the claim form the sole cause of the injury(ies) sustained? ☐ Yes ☐ No
(If not, give the particular of any contributing cause or causes.)

6. In your opinion, was the injury caused in any way by illness? ☐ Yes ☐ No
(If yes, what was the date you provided treatment for the illness?)
(Month/Day/Year)

7. Did the patient ever consult you before? ☐ Yes ☐ No
(If yes, please state the dates and the ailments for which you attended.)

Signature of Physician		Date signed *(Month/Day/Year)*	
Name of facility		Phone Number	
Address - Street	City	State	Zip Code