

Instructions for Completing Group Life Insurance Statement of Review

- **Continued Protection (Premium Waiver During Total Disability)**
- **Continued Life Insurance During Total Disability**
- **Total & Permanent Disability**

Employer's Statement

1. The Employer's Statement should be completed by someone who is familiar with the employee's potential eligibility for Premium Waiver, Continued Insurance or Total Permanent Disability.
2. Complete Sections 1, 2, & 3 of the Employer's Statement and sign at the bottom of the page.

Note: Failure to complete all sections or sign the Employer's Statement will cause a delay in processing.

3. Give the completed Employer's Statement and all remaining pages including this page to the employee for further processing. You may wish to retain a copy of the completed Employer's Statement for your records.
4. Contact MetLife with any questions you may have when completing this form.

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.

Employee's Statement

1. The Employee's Statement must be completed by the employee or his/her legal representative. 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 and 2 of the Employee's Statement.
3. Sign the following pages:
 - a) the Authorization to Disclose Information About Me
 - b) the Attending Physician Statement, Section A
4. Give the Attending Physician Statement to your treating physician for completion.
5. Contact MetLife with any questions you may have when completing this form.
6. Place your name and Social Security number in the allocated area of each page.
7. Submit the entire form to MetLife at the above address.

GROUP LIFE INSURANCE STATEMENT OF REVIEW



Metropolitan Life Insurance Company
 P.O. Box 14632
 Lexington, KY 40512-4632
 Phone: 1-800-300-4296

Please check all appropriate boxes for this submission

- Continued Protection (Premium Waiver During Total Disability)
- Continued Life Insurance During Total Disability
- Total & Permanent 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	<input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	Base Wages as of Last Date Worked \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> 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 or been ported to an Individual Policy? (Yes/No)
Basic Life									
Supplemental / Optional Life									
GUL									
Does your Company Provide Retirement Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No			Check Type of Benefit: <input type="checkbox"/> Normal <input type="checkbox"/> Disability Would the Employee Qualify? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If "Yes," please answer these questions:			Date on which Employee would qualify? _____						

Employer's Authorized Representative

Name _____ Title _____ Phone # _____

Signature _____ Date Signed _____

GROUP LIFE INSURANCE STATEMENT OF REVIEW



Metropolitan Life Insurance Company
 P.O. Box 14632
 Lexington, KY 40512-4632
 Phone: 1-800-300-4296

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)
Home Phone # () -		Occupation		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other	
				Sex <input type="checkbox"/> M <input type="checkbox"/> F	

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: _____

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 Signed

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, Idaho, 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, 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 civil fines and criminal penalties.

California: For your protection, California law requires the following to appear on this form: 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: A 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.

Indiana: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, files any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information commits a felony.

Kentucky: A 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.

Maine, Minnesota, Tennessee, Virginia, 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 include imprisonment, fines and denial of insurance benefits.

FRAUD WARNINGS, CON'T.

New Hampshire: A person who, with a purpose to injure, defraud or deceive any insurance company files a statement of claim containing 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.

New York (AD&D): 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 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.

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.

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.

ATTENDING PHYSICIAN STATEMENT

MetLife[®]
 Metropolitan Life Insurance Company
 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 Signed _____	

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)

_____	_____
_____	_____
_____	_____

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)

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

Hours	(check)			Yes	No
Sit 0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	Climb	Yes	No
Stand 0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	Twist/bend/stoop	Yes	No
Walk 0 1 2 3 4 5 6 7 8	<input type="checkbox"/> Continuously	<input type="checkbox"/> Intermittently	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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 to 20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51 to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/>	<input type="checkbox"/>
Never:	<input type="checkbox"/>	<input type="checkbox"/>

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
- Occupational Therapy
- Cardiac Rehabilitation
- Pain Management Program
- Work Hardening Program
- Job Modification
- Vocational Rehabilitation
- Psychological Counseling
- Other _____

Physician:

Name _____ Degree/Specialty _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone # (_____) _____ Fax # (_____) _____ Tax ID # _____

Contact person if additional information is necessary _____

Signature _____ Date Signed _____