MetLife

TO THE EMPLOYER

WHEN THIS FORM SHOULD BE COMPLETED

You should **always** complete this form when the insured or covered dependent suffers an accidental injury that results in a covered loss.

In the case of **accidental death**:

- The Accidental Death benefit should be claimed on the Life Insurance Claim Form.
- The attached form should be completed and sent to the claimant also, in order to give the claimant the opportunity to make a claim for any of the additional benefits included in your plan.

In the case of **accidental dismemberment**:

The claimant must claim the Accidental Dismemberment benefit and any of the accompanying additional benefits included in your plan on this form only. The completion of the Life Insurance Claim Form is not necessary.

INSTRUCTIONS FOR COMPLETION

1. Complete **Part A (Employer's Statement)** on pages 3 and 4.
2. Give the claimant the entire claim form so that he or she may complete **Part B (Claimant's Statement)**, and make a claim for the applicable benefits. Depending upon the benefit claimed, it may also be necessary for the claimant to have his or her attending physician complete **Part C (Attending Physician's Statement)**. The claimant will then return the claim form to MetLife:
3. Contact the MetLife Administrator responsible for your group if you have further questions.

TO THE CLAIMANT

We at MetLife are sorry for your loss. To ensure that you have knowledge of all of the benefits that are included in the Group Accidental Death and Dismemberment (AD&D) plan, this claim form is being sent to you.

The employer has completed **Part A, the Employer's Statement**, which is on pages 3 and 4, and has indicated which benefits are included in the plan. The following page (2) gives a brief description of all of the benefits listed, but only those that have been checked off by the employer on the Employer's Statement are available to you.

If you feel that the circumstances of your loss make you eligible for any of these benefits and wish to file a claim, please complete **Part B, the Claimant's Statement** that is on pages 6 and 7, and check off the benefit(s) that you are claiming. If you are claiming any of the benefits in the second column, it will be necessary for the attending physician to complete the applicable portions of **Part C (Attending Physician's Statement)** that is on pages 8-10.

When the applicable parts of the claim form have been completed, please return the entire form to the MetLife Group Life Claims Office for processing:

MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505
1-800-638-6420

Upon receipt, your claim will be thoroughly reviewed for conformity with the plan provisions. It may be necessary for MetLife to request additional information before a final determination regarding potential payment is made.

DESCRIPTION OF BENEFITS

If the employee or covered dependent satisfies the qualifications for any of the benefits listed below, and if that benefit is included in the employer's plan, an additional amount is payable.

Air Bag – the employee or covered dependent is driving or riding in a passenger car that is involved in an accident. As a result of the accident, the air bag deploys. The employee or covered dependent dies from the injuries sustained in the accident. (The employee or covered dependent must have also been wearing a properly fastened seat belt.)

Child Care – the employee dies as a result of an accidental injury. On the date of death, a child younger than 12 years old was enrolled in a child care center, or enrolls within 12 months of the death.

Child Education – the employee dies as a result of an accidental injury. On the date of death, a child was enrolled in an accredited school above the 12th grade level, or is in 12th grade and enrolls within 12 months of the death.

Repatriation of Remains – employee or covered dependent dies as a result of an accidental injury, and the death occurred at least 100 miles from his/her principal residence.

Seat Belt – the employee or covered dependent is driving or riding in a passenger car that is involved in an accident. At the time of the accident, the employee or covered dependent was wearing a properly fastened seat belt. The employee or covered dependent dies from the injuries sustained in the accident.

Workplace Felonious Assault – employee suffers an accidental injury caused by a felonious assault committed at the policyholder's place of business, or while the employee is engaged in policyholder business. The assault is committed by someone other than the employee, the employee's immediate family, or another employee of the policyholder.

BENEFITS REQUIRING COMPLETION OF ATTENDING PHYSICIAN'S STATEMENT (PART C)

If the employee or covered dependent satisfies the qualifications for any of the benefits listed below, and if that benefit is included in the employer's plan, an additional amount is payable.

Limb/Digit Amputation – employee or covered dependent suffers the loss of a body part as a result of an accident, and a physician verifies the location of the severance.

Loss of Hearing – employee or covered dependent suffers entire and irrecoverable loss of hearing in both ears as a result of an accident, and a physician verifies the degree of loss.

Loss of Speech – employee or covered dependent suffers entire and irrecoverable loss of speech as a result of an accident, and a physician verifies the degree of loss.

Loss of Vision – employee or covered dependent suffers permanent and uncorrectable loss of sight in one or both eyes as a result of an accident, and a physician verifies the degree of loss.

Paralysis – employee or covered dependent suffers paralysis as a result of an accident, and a physician determines that the paralysis is permanent, complete, and irreversible.

Metropolitan Life Insurance Company
Statement of Claim for
Accidental Dismemberment Benefits and Additional Benefits

Part A - Employer's Statement **(To be Completed by the Employer)** (Please Answer All Questions)

Employee Social Security Number	Name of Insured Employee (First, Middle, Last)		☐ Male ☐ Female
Date of Accident	Date of Death (if applicable)	Date of Loss (if applicable)	Date of Birth

Was Insurance ever assigned? ☐ Yes ☐ No (If yes, please attach a copy of assignment and all related papers)

Date of Hire	Basic Annual Earnings $	as of Date

Employee is: ☐ Hourly or ☐ Salaried
☐ Union or ☐ Non-Union
☐ Exempt or ☐ Non-Exempt

Employee's full amount of AD&D Insurance $________ Report # 143584 Sub 0001 Branch 0001
Employee's full amount of OAD&D Insurance $________ Report # 143584 Sub 0001 Branch 0001
Employee's full amount of DAD&D Insurance $________ Report # 143584 Sub 0001 Branch 0001

☐ Active Employee	Effective date of amount claimed	☐ Retired Employee	Date Retired

If the employee was not actively at work at date of death or loss, please indicate status (Choose one):
☐ Regular Retiree ☐ Retired Due to Disability ☐ Terminated Due to Disability
☐ Terminated for any Other Reason ☐ Leave of Absence/Layoff/Sick Leave
☐ Disabled (Not terminated or retired)

Date Last Worked	Reason for Stopping

Date Premium Payments for Employee Stopped

Was the Employer/Employee relationship terminated before the death or loss?	☐ Yes ☐ No	Date	Reason
Was Life Insurance Cancelled?	☐ Yes ☐ No	Date	
Was a Total and Permanent Disability or Continued Protection (CP) disability waiver claim ever filed with MetLife for this employee?	☐ Yes ☐ No	Disability Case Number	

Dependent Claim Only

Date of Death (if applicable)	Date of Loss (if applicable)	Date of Birth	Dependent Social Security Number
Relationship (Spouse/Child)	Name of Dependent (First, Middle, Last)		☐ Male ☐ Female

Please indicate below which of the benefits under each product are included in your benefit package by checking off the applicable boxes. Those benefits identified with an "(S)" are standard to that product, while those identified with an "NA" are not available with that product. (All of the products and benefits listed may not be included in your benefit package.)

	AD&D	OAD&D	DAD&D
AIR BAG USE	☐ (S)	☐ (S)	☐ (S)
CHILD CARE	☐ (S)	☐ (S)	NA
CHILD EDUCATION	☐ (S)	☐ (S)	NA
LIMB/DIGIT AMPUTATION	☐	☐	☐
LOSS OF HEARING	☐	☐	☐
LOSS OF SPEECH	☐	☐	☐
LOSS OF VISION	☐	☐	☐
PARALYSIS	☐	☐	☐
REPATRIATION OF REMAINS	☐	☐	☐
SEAT BELT	☐ (S)	☐ (S)	☐ (S)
WORKPLACE FELONIOUS ASSAULT	☐	☐	NA

Date Signed ____________________________

Signature of Employer Representative ____

Print Name ____

Name and Address of Employer State of South Carolina Budget and Control Board ____________

____

____

Phone ____________________________

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.

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.

Arkansas, District of Columbia, Louisiana, Minnesota, New Mexico, Ohio, Oregon 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.

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 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, 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.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

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, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 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 files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

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: Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

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

MetLife

Part B - Claimant's Statement (To be Completed by the Claimant)

Information about you:

1. Your Name (First, Middle, Last)	2. Social Security Number
3. Date of Birth	4. Phone Number Day: Evening:
5. Mailing Address	
6. Fax Number (Optional)	
7. Relationship to the Insured: ☐ Spouse ☐ Child ☐ Parent ☐ Self ☐ Other (explain)	

Information about the Insured: (It is not necessary to complete this section if you are the claimant as well as the insured)

1. Name (First, Middle, Last)
2. Resident Address
3. Marital Status
   ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Benefits Claimed:

After referring back to the Employer's Statement to verify which benefits are available under the plan, please check off the box(es) to the left of the benefit(s) that you are claiming. If you are claiming any of the benefits in the second column, please have the attending physician complete the applicable portions of Part C (Attending Physician's Statement) of this form. It may be necessary for MetLife to request additional information before a final determination regarding potential payment is made.

☐ AIR BAG	☐ LIMB/DIGIT AMPUTATION
☐ CHILD CARE	☐ LOSS OF HEARING
☐ CHILD EDUCATION	☐ LOSS OF SPEECH
☐ LOSS OF LIFE	☐ LOSS OF VISION
☐ REPATRIATION OF REMAINS	☐ PARALYSIS
☐ SEAT BELT	
☐ WORKPLACE FELONIOUS ASSAULT	

NOTE: Please refer back to Part A5 of the Employer's Statement to verify which of the benefits below are available under the plan. If there are no eligible survivors (refer to Description of Benefits) for any of the benefits below, the beneficiary is eligible for an additional payment. Please answer the following questions.

Benefit		
CHILD EDUCATION	Are there eligible survivors?	☐ Yes ☐ No
CHILD CARE	Are there eligible survivors?	☐ Yes ☐ No

Certifications and 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 consent to the pro rata deduction of any contributions owed by the insured from insurance proceeds paid to me.
3. I have read the applicable Fraud Warning(s) provided in this form.

Under penalty of perjury, I certify:

1. **That the number shown on this form is my correct taxpayer identification 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: You must cross out item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest and dividend income on your tax return.)

The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding.

Please sign below (include first and last name). If Beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor.

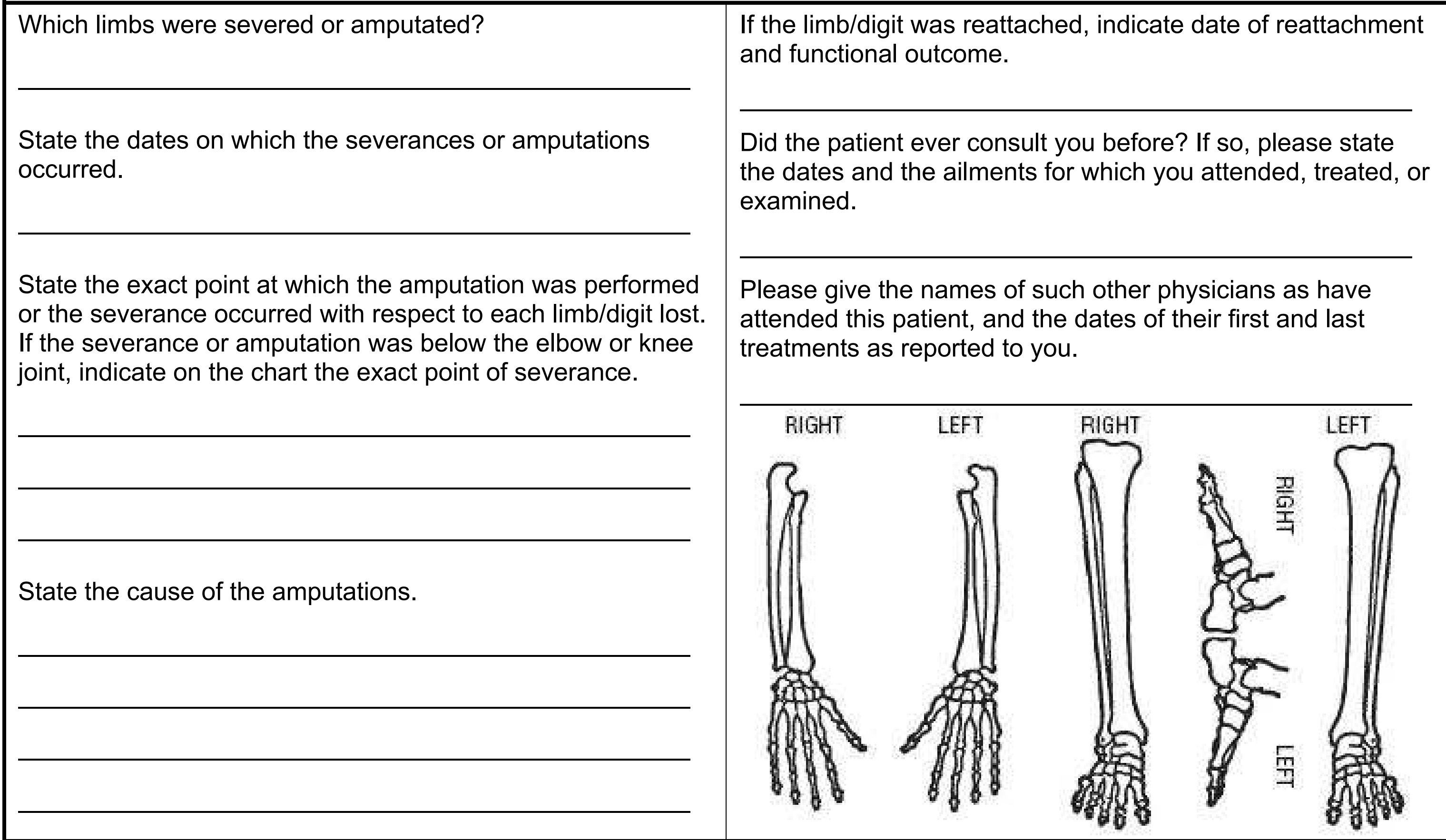
______________________________ ______________________________

Claimant Signature — Date Signed

Part C - Attending Physician's Statement **(To be completed only when any of the benefits on page 2 are being claimed.)**

1. Name of patient (First, Middle, Last)	Age
2. Date of accident causing present loss (Month, Day, Year)	
3. Date first consulted on account of the injury described (Month, Day, Year)	
4. Date of last treatment for this condition (Month, Day, Year)	
5. In your opinion, was the injury described solely responsible for the loss? ☐ Yes ☐ No If not, give the particular of any contributing cause or causes	
6. In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No If yes, what was the date you provided treatment for the illness?	
7. Names of any other physicians who treated the patient for a contributory condition	

Please also complete the applicable section for the benefit being claimed.



To be Completed Only For Limb/Digit Amputations

Which limbs were severed or amputated?

____

State the dates on which the severances or amputations occurred.

____

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.

____

____

____

State the cause of the amputations.

____

____

____

____

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

____

Did the patient ever consult you before? If so, please state the dates and the ailments for which you attended, treated, or examined.

____

Please give the names of such other physicians as have attended this patient, and the dates of their first and last treatments as reported to you.

____

Signature ______________________________ Date Signed ______________________________
(Attending Physician) (Month) (Day) (Year)

Address ______________________________

Phone Number ______________________________

To be Completed Only For Loss of Vision

Has the patient had entire and irrecoverable loss of sight following the injury?

☐ Yes ☐ No

If yes, please answer the following:

Give the date you first determined vision was irrecoverably reduced to 20/200 (Snellen Notation) or less with correction and the vision then remaining in each eye.

Date ______________________________

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

Give the date and vision found on last eye examination.

Date ______________________________

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

State the cause of loss of vision:

____

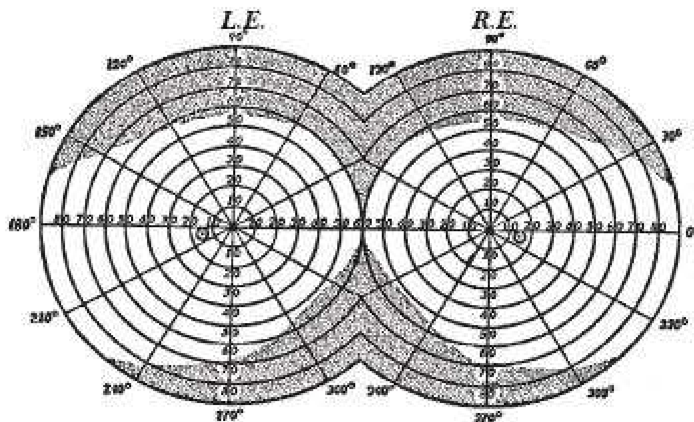
____

____

Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.	☐ Operation	☐ Treatment
O.S.	☐ Operation	☐ Treatment

If fields of vision are contracted, show contraction on chart below.



Signature ______________________________ (Attending Physician)

Date Signed ______________________________ (Month) (Day) (Year)

Address ______________________________

Phone Number ______________________________

To be Completed Only For Paralysis

Give the date you first determined paralysis was permanent, complete and irreversible, the etiology of the paralysis, and method of correction and result.

a) Date ______________________________

b) Etiology ______________________________

Specific limb(s) paralyzed ______________________________

____

____

Location of lesion(s) responsible ______________________________

____

____

Type of lesion(s) responsible ______________________________

____

____

Test results which document paralysis (i.e., physical exam, EMG, nerve conduction tests) ______________________________

____

____

Method of correction

Functional result of correction ______________________________

____

____

To be Completed Only For Loss of Speech

Has the patient had entire and irrecoverable loss of speech which has lasted continuously for 6 consecutive months following the injury? ☐ Yes ☐ No

If yes, please answer the following:

Give the date you first determined speech was irrecoverably lost and the specific etiology for absence of speech (vocalization) and method and results of correction.

a) Date ______________________________

b) Specify basis for speech loss:

	Description Uncorrected	Corrected Method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

Give the date and the specific etiology for absence of speech (vocalization) and method and results of correction which allowed you to determine the speech loss lasted continuously for 12 consecutive months following the injury.

a) Date ______________________________

b) Specify basis for speech loss:

Description Uncorrected	Corrected Method

To be Completed Only For Loss of Hearing

Has the patient had entire and irrecoverable loss of hearing which has lasted continuously for 6 consecutive months following the injury?

☐ Yes ☐ No If yes, please answer the following:

Give the date you first determined hearing was irrecoverably lost and the residual hearing (dB) uncorrected and corrected as tested by audiometer in a soundproof room.

a) Date ______________________________

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Give the date and test results which allowed you to determine the hearing loss lasted continuously for 6 consecutive months following the injury.

a) Date ______________________________

b) Audiometry:

	Left Ear Uncorrected / Corrected	Right Ear Uncorrected / Corrected
500 Hz	/	/
1,000 Hz	/	/
2,000 Hz	/	/
3,000 Hz	/	/

Signature ______________________________ Date Signed ______________________________

(Attending Physician) (Month) (Day) (Year)

Address ______________________________

Phone Number ______________________________