Statement of claim for Accidental Dismemberment benefits and Additional benefits

Metropolitan Life Insurance Company

To the Employer/Recordkeeper

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 other than death.Completion of a separate life insurance claim form is not necessary.

Please note that this form may include benefits that are not part of your plan; MetLife will review the claim in accordance with your specific plan provisions.

Instructions for completion

1. Complete **Employer's Statement** and provide the entire form to the claimant.
2. Instruct the claimant to complete **Claimant's Statement**, and submit the entire form, plus any additional documents and forms, such as the **Attending Physician Statement** to MetLife.
3. Contact the MetLife Administrator responsible for your group if you have further questions.

To the claimant

To ensure that you have knowledge of all of the benefits that are included in the Group Accidental Dismemberment (AD&D) plan, this claim form is being provided to you.

The employer has completed the **Employer's Statement**. The Description of Benefits below provides a list of benefits that may be available under AD&D plans ; however please be aware that your particular plan may not include all of these benefits. Please refer to your group certificate or Summary Plan Description for specific plan details.

To file a claim for AD&D benefits, complete the **Claimant's Statement**. Your claim may also require that your physician complete an **Attending Physician's Statement**.

Upon completion, send all parts of the form to MetLife:

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

Fax:
570-558-8645

Upon receipt, your claim will be thoroughly reviewed. It may be necessary for MetLife to request additional information before a final determination is made.

Description of benefits

If the insured suffers an accident and meets the conditions for any of the benefits listed below, and if that benefit is included in the employer's plan, an accidental dismemberment benefit or additional amount may be payable.

Refer to your group certificate or Summary Plan Description for a complete description of these benefits. Not all plans include these benefits.

- Permanent and Irreversible Brain Damage
- Third Degree Burn
- Coma
- Unavoidable Exposure to the Elements
- Limb/Digit Amputation
- Wheelchair Access Modification
- Entire and Irrevocable Loss of Hearing in Both Ears
- Entire and Irrevocable Loss of Speech
- Permanent and Uncorrectable Loss of Vision in One or Both Eyes
- Complete, Permanent and Irreversible Paralysis
- Rehabilitative Physical Therapy

MetLife

Statement of claim for Accidental Dismemberment benefits and Additional benefits

Metropolitan Life Insurance Company

SECTION 1: Employer's statement *(To be Completed by the Employer) (Please Answer All Questions)*

Insured employee - First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*	Social Security number	☐ Male ☐ Female

Date of accident *(mm/dd/yyyy)*	Date of loss *(if applicable)*	Date of hire *(mm/dd/yyyy)*

Base Annual Earnings	As of date *(mm/dd/yyyy)*

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

Was Insurance ever assigned? ☐ Yes ☐ No

(If yes, please attach a copy of assignment and all related papers)

Insurance Type	Amount	Group *(Report)* #	Sub/Div.	Branch/Class
Employee's full amount of VAD&D Insurance	$			
Employee's full amount of AD&D Insurance	$			
Employee's full amount of OAD&D Insurance	$			
Employee's full amount of DAD&D Insurance	$			

☐ Active Employee	Effective date of amount claimed	☐ Retired Employee	Date retired *(mm/dd/yyyy)*

If the employee was not actively at work at date of death or loss, please indicate status *(Choose one):*

☐ Regular retiree ☐ Terminated for any other reason ☐ Leave of Absence/Layoff/Sick leave

☐ Retired due to disability ☐ Terminated due to disability ☐ Disabled *(Not terminated or retired)*

What was the last date the employee was physically doing work?	Reason for stopping

Date premium payments for employee stopped	Was life insurance cancelled? ☐ Yes ☐ No	Date *(mm/dd/yyyy)*

Was the Employer/Employee relationship terminated before the death or loss? ☐ Yes ☐ No	Date *(mm/dd/yyyy)*	Reason

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

SECTION 2: Dependent claim only

Date of loss *(mm/dd/yyyy)* | Date of birth *(mm/dd/yyyy)* | Dependent social security number

Relationship *(Spouse/Child)*

☐ Male
☐ Female

Name of dependent

First name | Middle name | Last name

Address | City | State | ZIP

SECTION 3: Signature

Employer name | Phone number

Address | City | State | ZIP

First name | Middle name | Last name

Sign Here Signature of Employer representative | Date *(mm/dd/yyyy)*

Metropolitan Life Insurance Company

Your AD&D insurance claim kit

Helping you submit your claim

Our standard method of paying the proceeds of your claim is to deposit them into a convenient Total Control Account. You'll find more details in the enclosed document, *"About the Total Control Account."*

We're here to help
We recognize this may be a challenging time for you. If you have questions, or need help preparing your claim, call us at **1-800-MET-6420 (1-800-638-6420)**. Our Customer Service Center is open Monday through Thursday, 8:00 a.m. to 8:00 p.m. EST, and Friday 8:00 a.m. to 5:00 p.m. EST.

Sincerely,

MetLife
U.S. Life Insurance Claims

About the total control account®

A convenient place to hold the proceeds from your claim while you decide what to do with the money

How the account works

The Total Control Account (TCA) is a draft account that works like a checking account:

- When your account is open, MetLife1 will send you a package which includes additional details about the TCA. We pay the full amount owed to you by placing your proceeds into the TCA and providing you a book of drafts. You can use the drafts like you would use checks.
- You can use a single draft to access the entire proceeds or several drafts for smaller amounts *(as little as $250)*. There are no limits on the number of drafts you can write. Processing time is similar to check processing.
- You also may conveniently use your TCA as a source of funds to pay your bills online or by phone.
- You earn interest on the money in your account from the date your account is open.
- We'll send you an account statement each month when there is activity in your account. If you have no activity, we'll send you a statement once every three months.
- You can name a beneficiary for your account. We'll include a beneficiary form in the package we send you when we open your account.

Interest rates and guarantees

The interest rate on your account is set weekly, and will always be the greater of the guaranteed rate stated in your TCA package, or the rate established by one of the following indices: the prior week's Money Fund Report Averages™/Government 7-Day Simple Yield, or the Bank Rate Monitor™ National Money Market Index. We calculate interest daily and compound it, so you earn interest on your interest. The interest is added to your account monthly. The interest earnings generally are taxable so you should speak with your tax advisor.

No monthly maintenance fees

There are no monthly maintenance or service fees on your TCA, no charges for making withdrawals or writing drafts, and no cost for ordering additional drafts. You may be charged for special services or an overdrawn TCA, and the current fees *(subject to change)* for those services are: draft copy $2; stop payment $10; wire transfer $10; overdrawn TCA $15; overnight delivery service $25.

Other important information

- If you do not want a TCA, you may request a check by writing "check" beneath your signature on the attached claim form.
- Your Total Control Account is backed by the financial strength of MetLife. The assets backing the funds are held in MetLife's general account and are subject to MetLife's creditors. In addition, while the funds in your account are not insured by the FDIC, they are guaranteed by your state insurance guarantee association. The coverage limits vary by state. Please contact the National Organization of Life and Health Insurance Guaranty Associations *(www.NOLHGA.com or 703-481-5206)* to learn more. FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.
- If there is no activity on your account for a period of time *(typically three years, but this may vary by state)*, state regulations may require that we contact you at the address we have on file. If we aren't able to reach you, we may be required to close your account and transfer the funds to the state.
- We may limit or suspend your access to the funds in your account if we suspect fraud or if there was an error in opening your account.
- We use the services of The Bank of New York Mellon, 701 Market Street, Philadelphia, PA 19106, for Total Control Account recordkeeping and draft clearing.
- A TCA generally is not available if your claim is less than $5,000, you reside in a foreign country, or if the claimant is a corporation or similar entity.
- We may receive investment earnings from operating the Total Control Account. The performance results of any investments we make do not affect the interest rate we pay you.
- To learn more about TCA, please call us at 800-638-7283 *(TDD callers: 800-229-3037)* or write us at Metropolitan Life Insurance Company, Total Control Account, PO Box 6300, Scranton, PA 18505-6300.

[1] *"MetLife" means Metropolitan Life Insurance Company or the MetLife affiliate that issued the underlying policy*

Total Control Account® is a registered service mark of Metropolitan Life Insurance Company.

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 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: 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.

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.

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.

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.

MetLife

Statement of claim for Accidental Dismemberment benefits and Additional benefits

Metropolitan Life Insurance Company

Section 1: Claimant's statement *(To be completed by the claimant)*

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

Insured employee - First name | Middle name | Last name

Employer Name

Address | City | State | ZIP

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Section 2: Information about you

First name | Middle name | Last name

Social Security number | Date of birth *(mm/dd/yyyy)* | Phone number - Day | Phone number - Evening

Address | City | State | ZIP

Fax number *(optional)*

Relationship to the insured ☐ Spouse ☐ Child ☐ Parent ☐ Self

☐ Other *(explain)* _____

When did the accident happen? Date *(mm/dd/yyyy)* at Hour ☐ a.m ☐ p.m

Where did the accident happen? City | State

Give a brief description of the accident

Total control account *(TCA)*

Our standard payment method is in the form of a **Total control account**. A personalized draftbook and a kit that includes information about your TCA will be sent to you if an Account is established. Your TCA will be guaranteed by MetLife and your TCA will be accessible to you when you need it.

Insured employee - First name	Middle name	Last name

Insured's employer's Name

Section 3: 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. That any contributions owed by the insured will be deducted from insurance proceeds paid to me.
3. 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 the claim for each such violation.

Under penalty of perjury, I certify:

1. **That the number shown as my Social Security Number or Tax Identification Number in "Information about you" above is my correct taxpayer identification number, and**
2. **That I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and**
3. **I am a U.S. citizen, resident alien, or other U.S. person*, and**
4. **I am not subject to FATCA reporting because I am a U.S. person* and the account is located within the United States.**

(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 or dividend income on your tax return.)

* If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out items 3 and 4 above, and complete and submit form W-8BEN *(individuals)* or W-8BEN-E *(entities)*.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required 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. If no legal guardian is appointed to handle the minor's estate, a responsible adult should complete and sign the claimant statement on behalf of the minor beneficiary. If a legal guardian of the minor child's estate has been or will be appointed, the guardian must complete and sign the claimant statement. Be sure to include a copy of the court-issued guardianship papers in the claim submission to MetLife.

Sign Here	Signature of Claimant	Date *(mm/dd/yyyy)*

MetLife

Statement of claim for Accidental Dismemberment benefits and Additional benefits

Metropolitan Life Insurance Company

Insured employee - First name	Middle name	Last name

Insured's employer's Name

SECTION 1: Attending physician's statement

Patient - First name	Middle name	Last name

Age	Date first consulted on account of the injury described *(mm/dd/yyyy)*

Date of accident causing present loss *(mm/dd/yyyy)*	Date of last treatment for this condition *(mm/dd/yyyy)*

Describe the exact nature, location, and extent of all injuries sustained

Was the injury described solely responsible for the loss? ☐ Yes ☐ No

If not, give the particular of any contributing cause or causes.

Names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you.

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?

Insured employee - First name	Middle name	Last name

Insured's employer's Name

Did the patient ever consult you before? ☐ Yes ☐ No

If yes, please state the dates and the ailments for which you attended, treated, or examined.

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

SECTION 2: To be completed only for Limb/Digit amputations

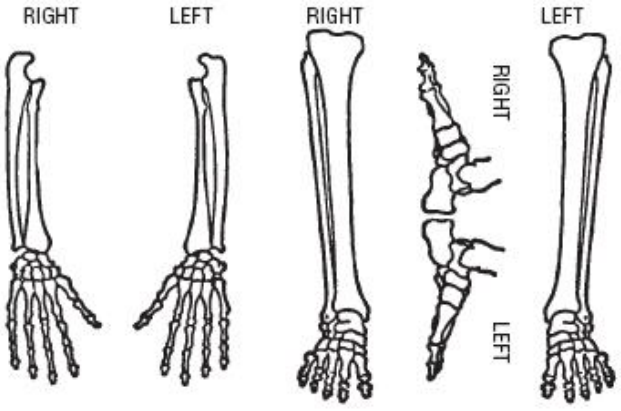
What limb/digit was severed or amputated?

State the dates on which the severance or amputation occurred.

State the cause of the amputation.

If the 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.



Insured employee - First name	Middle name	Last name

Insured's employer's Name

Attending physician - First name	Middle name	Last name	
Address	City	State	ZIP
Name of facility		Phone number	
Sign Here	Signature of attending physician		Date *(mm/dd/yyyy)*

SECTION 3: 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 *(mm/dd/yyyy)* _____

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

(Snellen Notations)

Give the date and vision found on last eye examination. Date *(mm/dd/yyyy)* _____

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

(Snellen Notations)

State the cause of loss of vision:

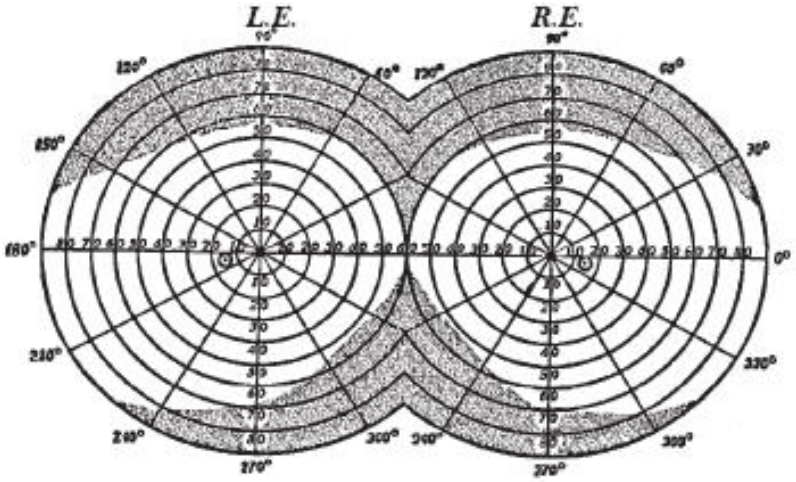
Indicate whether recovery or useful vision is possible by operation or treatment.

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

Insured employee - First name	Middle name	Last name

Insured's employer's Name

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



SECTION 4: To be completed only for burn

Has the patient suffered third degree burns as a result of an accident? ☐ Yes ☐ No

What percentage of the body surface suffered third degree burns? _____ %

Location of third degree burns

SECTION 5: To be completed only for rehabilitative physical therapy

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* _____

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss? ☐ Yes ☐ No

Date therapy prescribed *(mm/dd/yyyy)* _____

Name of facility		Phone number
Address	City	State ZIP
Attending physician - First name	Middle name	Last name
Sign Here Signature of attending physician		Date *(mm/dd/yyyy)*

Insured employee - First name	Middle name	Last name

Insured's employer's Name

SECTION 6: To be completed only for paralysis

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

Date *(mm/dd/yyyy)*	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

SECTION 7: To be completed only for loss of speech

State duration in months of patient's entire and irrecoverable loss of speech following the injury.

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech *(vocalization)* and method and results of correction. Date *(mm/dd/yyyy)* _____

Specify basis for speech loss:

	Description uncorrected	Corrected method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

Insured employee - First name	Middle name	Last name

Insured's employer's Name

SECTION 8: To be completed only for loss of hearing

State duration, in months, of patient's entire and irrecoverable loss of hearing following the injury?

Date you first determined hearing was irrecoverably lost and the residual hearing *(dB)* uncorrected and corrected as tested by audiometer in a soundproof room. Date *(mm/dd/yyyy)* _____

Audiometry:

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

Date the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above. Date *(mm/dd/yyyy)* _____

Audiometry:

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

SECTION 9: To be completed only for wheelchair access modification

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* _____

Does the patient now require permanent use of a wheelchair for mobility? ☐ Yes ☐ No

Is the wheelchair requirement the direct and sole cause of the accidental injury? ☐ Yes ☐ No

Name of facility		Phone number
Address	City	State ZIP
Attending physician - First name	Middle name	Last name
Sign Here Signature of attending physician		Date *(mm/dd/yyyy)*

Insured employee - First name | Middle name | Last name

Insured's employer's Name

SECTION 10: To be completed only for brain damage

Has the patient suffered permanent and irreversible physical damage to the brain as a result of an accidental injury, causing the complete inability to perform all the substantial and material functions and activities normal to everyday life? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* | Date brain damage manifested itself *(mm/dd/yyyy)*

Was the patient hospitalized as a result of the accidental injury? ☐ Yes ☐ No

Dates of hospitalization:

State duration, in months, brain damage persisted after the injury?

SECTION 11: To be completed only for coma

Did the patient enter into a state of deep and total unconsciousness from which he/she cannot be aroused as a result of an accidental injury? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* | Date coma began *(mm/dd/yyyy)*

Is the patient still in a coma? ☐ Yes ☐ No

If the patient is not in a coma now, date coma ended *(mm/dd/yyyy)*: _____

SECTION 12: To be completed only for exposure

Was the patient involved in an accident that resulted in loss of life or limb due to unavoidable exposure to the elements? ☐ Yes ☐ No

If loss of life, please explain how the exposure resulted in death.

If loss of limb, which limbs were lost?

Insured employee - First name	Middle name	Last name

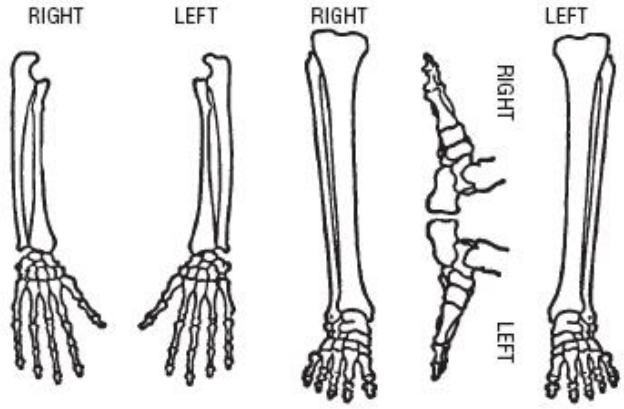
Insured's employer's Name

State the dates on which amputations occurred.

State the cause of the amputation.

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

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



Attending physician - First name	Middle name	Last name	
Address	City	State	ZIP
Name of facility		Phone number	
Sign Here Signature of attending physician		Date *(mm/dd/yyyy)*	