



MetLife
 Attn: Expatriate Benefits
 600 King Street
 Wilmington DE, 19801 USA
 Toll Free (Within U.S.): 1-800-451-1847
 Direct: +1-302-661-8674
 Fax: +1-302-427-0817
 Email: wilmclaims.metlifeexpat@alico.com
 www.metlifeexpat.com

INTERNATIONAL CLAIM FORM

To be used by employees who reside outside the United States for services rendered outside the United States
 Medical, Dental and Vision

Please mail or fax this completed form with itemized bills and receipts to the address or fax number listed above. Please tape small receipts on 8.5 X 11 inch or ISO A4 paper. Please do not staple receipts to claim form. If already enrolled with electronic fund transfer (EFT), we will automatically send payment by wire transfer if criteria are met, unless noted otherwise below. *To enroll for ETF, please download a Wire Transfer Request Form from our website at www.metlifeexpat.com

PLEASE PRINT ALL INFORMATION CLEARLY

Employee's Name:

Part A Employee Information:

First	Middle	Last	Employer Name	Group Policy Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mailing Address			Email	<input type="text"/>
City	State	Postal Code	Country	Birth Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Is this a permanent change of address?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Employee status	<input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Deceased

Patient's Name:

Part B

Patient's Gender:

Relationship to Employee:

First	Middle	Last	Birth date	<input type="checkbox"/> Male	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Female	<input type="checkbox"/> Child	<input type="checkbox"/> Other

Does your family have any other form of medical or dental coverage? If so, please provide details so that we may coordinate coverage.

Yes No

Details

Part C

Diagnosis or Chief Complaint	<input type="text"/>
Is condition due to an injury arising out of patient's employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part D

Payment to Employee: Please indicate where the payment should be sent.

AUTHORIZATION TO PAY PROVIDER (Contingent upon provider accepting assignment)

Check (payment to address as listed above)

Make payment directly to provider (please sign below)

Wire Transfer (*if not already enrolled, please see above)

Currency Preference

(If currency is not specified, payment will be made in U.S. Dollars)

Employee's Signature

Date

Part E

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator, and will be used for the purpose of claims administration and evaluation, utilization review and financial audit. This authorization shall remain valid and effective from the date of signing until revoked in writing or for the term of coverage for the policy identified above, provided such information shall be retained by the Administrator, if required by law. This authorization includes any transfer of medical information from outside the United States, including the European Economic Area, into the United States in order to process claims and service my insurance benefits.

I hereby certify the information I have provided on this form is correct to the best of my knowledge. I understand I may request and shall be furnished a copy of this authorization. I understand that a photocopy of this authorization is as valid as the original.

Date

Patient's Signature (Parent or guardian, if Minor Child)

Employee Signature

ATTENDING PHYSICIAN'S STATEMENT

If a full itemized bill is not available, have your physician complete this form and attach a receipt.

PART A

Patient's Name:	Date of Birth:
Employee's name if patient is a dependant:	

PART B

Diagnosis and Concurrent Conditions:	Accident Case? <input type="checkbox"/> Yes <input type="checkbox"/> No
(If accident case, please provide description)	
Is condition due to injury arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is condition due to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", what was the approximate date of LMP.	

REPORT OF SERVICES (Or attach itemized bill. If previous form submitted to this admission, you need only show dates and services since last report).

Date of Service	Place of Service**	Description of Surgical or Medical Services Rendered (if hospital confinement, name hospital)	Procedure Code - if used (if Code other than CPT-4 is used, give name)	Charges
Total Charges:				
Amount Paid:				
Balance Due:				

** ICD-9-CM - Int'l Classification of Diseases, 9th Rev. Clinical Modification

Place of Services (Use number Code)

- | | | |
|-----------------------|------------------------|---|
| 1. Doctor Office | 4. Outpatient Hospital | 7. Surgical Center |
| 2. Patient's Home | 5. Nursing Home | 8. Alcohol-Chemical Rehabilitation Center |
| 3. Inpatient Hospital | 6. Home Health Care | 9. Other Briefly Described |

I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN PERFORMED AND THAT THE FEES CHARGED DO NOT EXCEED THE FEES CHARGED TO PRIVATE AND NON-INSURED PATIENTS.

Physician's Name (Print)	Physician's Signature	Degree	Telephone No. Date

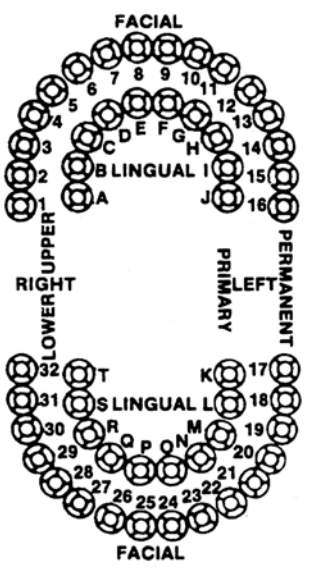
Street Address	City or Town	State or Province	Zip/Postal Code

FOR U.S. PHYSICIANS ONLY

Physician's Taxpayer (I.R.S.) ID Number:	Do you Accept Assignment? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

PART C - COMPLETED BY DENTIST

Dentist Name:		Is Treatment Result of Occupational Illness or Injury?	No	Yes	If YES, Enter Brief Description and Dates
Mailing Address:		Is Treatment Result of Auto Accident?			
City, State, Zip:		Other Accident?			
Dentist Soc. Sec. ORT. I.N.		Dentist License No	Are any Services covered by another Plan?		
Dentist Phone No		If Prosthesis, is this Initial Placement?			If No, Reason for Replacement Date of Prior Replacement _____
First Visit Date Current Series _____	Radiographs or Models Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how many?	Is the treatment for Orthodontics?		If Services already Commenced, enter Date Appliances Placed _____ Mos. Treatment Remaining _____
Place of Treatment <input type="checkbox"/> Office <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Other					

DENTISTS Pre-Treatment Estimate Statement of Actual Services		Examination and Treatment Plan - List in Order Tooth No. 1 through Tooth No. 32 Use Charting System Shown							
* Indicate Missing Teeth With an "X" 	Tooth # or Letter	Surfaces	Description of Services (Including X-Rays, Prophylaxis, Materials used , etc.	Date Services Performed			ADA Procedure Number	Fee	For Carrier Use Only
	Mo.	Da.	Yr.						
I Hereby Certify that The Procedures as indicated by Date _____ Total Fee Actually Charged _____ Have Been Completed									
SIGNED DENTIST DATE _____				CLAIM NO. _____					
Remarks for Unusual Services									

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.

CLAIM FILING INSTRUCTIONS

To file a claim, please follow the instructions listed below.

Part A: Employee Information: This section must be answered fully and clearly to establish positive identification of your eligibility. This enables us to have accurate and current mailing information for the proper mailing of your benefit check or information.

Part B: Answer this portion in detail if the claim is for a dependant. Please respond to the last inquiry in this section, if applicable, for both employee and dependant claims.

Part C: Please include a reason (chief complaint) for the treatment or the diagnosis provided by the physician in this section if confidentiality laws prohibit the provider from entering a diagnosis on the bill or if that bill is written in a language other than English.

Part D: Complete this section to indicate your desire for a check or wire transfer of funds. If you do not indicate a preference, and a wire transfer form has been completed, reimbursement will be sent based on the completed form. If a wire form has not been completed and you have not indicated a preference for reimbursement, a check will automatically be sent.

If you prefer a wire transfer of funds and have not already submitted the necessary form, please visit our web site at <http://www.metlifeexpat.com> to obtain the Wire Transfer Form.

If you prefer payment to be made directly to the provider (contingent upon provider accepting assignment), please sign where indicated.

Part E: This section must be signed by the patient. (If the patient is a minor child, the employee should sign the form.) This is your certification that the information is true and correct to the best of your knowledge.

ATTENDING PHYSICIAN'S STATEMENTS (Medical and Dental)

Your claim form contains a physician's statement for your convenience in filing your claim. Your doctor does not have to complete this statement if you have itemized bills or receipts of payment from the doctor. To be considered valid, your receipts must contain the following:

1. Name of the patient
2. Date of each service
3. Service performed
4. Amount charged for each service
5. The signature of the Provider or the Provider's representative
6. The Provider's name and address
7. The diagnosis (if confidentiality laws does not allow the provider to enter the diagnosis, enter the chief compliant on Part C of the claim form) symptoms or chief compliant on Part C of the claim form)
8. Drug bills must include the name of the medicine

SUBMITTING A CLAIM

Please mail, fax, or email a signed, completed claim form with itemized bills and receipts to:

MetLife
Attn: Expatriate Benefits
600 King Street
Wilmington, Delaware 19801 U.S.A.
Fax: +1 302-427-0817
Tel: +1 302-661-8674
wilmclaims.metlifeexpat@alico.com