Health Screening Benefit Claim Form

Please complete this form in its entirety

Metropolitan Life Insurance Company
Attn: Group Benefits
P.O. Box 80826
Lincoln, NE 68501-0826
Toll Free Phone:
1 866 626 3705
Fax Number: 1 855 306 7350
https://mybenefits.metlife.com

Return completed form by fax, mail or on-line at (https://mybenefits.metlife.com).

SECTION 1: Certificateholder Information

Certificateholder - First Name | Middle Name | Last Name

Certificate Number

Street Address | City | State | ZIP Code

Date of Birth *(mm/dd/yyyy)* | Gender ☐ Male ☐ Female | Social Security Number

Cell Phone Number | Daytime Phone Number | Evening Phone Number

EMAIL Address *(optional)* | Employer Name

SECTION 2: Patient Information *(if certificateholder is the patient, no need to complete the below)*

First Name | Middle Name | Last Name

Daytime Phone Number | Evening Phone Number | Relationship to Insured

SECTION 3: Medical Information

If a covered person undergoes a covered Health Screening test while such covered person is insured under this Policy, the following information must be provided to Us regarding the covered test performed.

Physician Name

Address | City | State | ZIP Code

Phone Number

Name of Testing Facility *(if different from Physician office)*

Address	City	State	ZIP Code

Phone Number

Date of Health Screening Test *(required) (mm/dd/yyyy)*	Test Type *(required)*

Date of Health Screening Test *(required) (mm/dd/yyyy)*	Test Type *(required)*

SECTION 4: Special Payment Instructions & Direct Deposits

- If you would like claim benefits 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

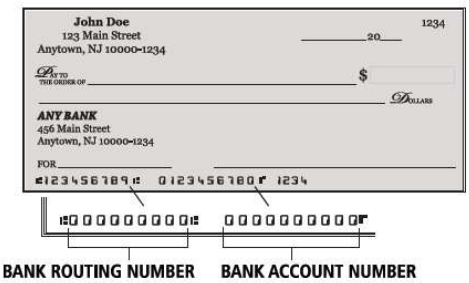
Bank Street Address	City	State	ZIP Code

Type of Account *(check one)*: ☐ Checking ☐ Savings

Be sure to confirm your account and routing numbers with your bank to ensure prompt processing

Bank Account Number

Bank Routing Number



Authorization & Signature

- I request MetLife to send my payments to the financial institution designated in Section 4 for deposit into my account. This agreement will remain in effect until MetLife receives notice from me to the contrary.
- I understand that MetLife will not be liable for any failure to change or terminate this agreement until a written request is received from me in satisfactory form and reasonable time has passed for MetLife to act upon it.
- If any overpayment is credited to my account in error, I authorize and direct my financial institution to debit my account and to refund such overpayment to MetLife.

Name *(Please print)*	Annuitant ID/Certificate Number
Sign Here Signature	Date *(mm/dd/yyyy)*

SECTION 5: Fraud Warning

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 insurer 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 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.

SECTION 6: Certification and Signature

By signing below, I acknowledge:

- All information I have given is true and complete to the best of my knowledge and belief.
- 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 claim for each such violation.

Under penalties of perjury, I certify that:

1. That the number shown on this form is my correct taxpayer identification / social security 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: If item 2 or 3 above is not true, cross out the applicable item(s). The IRS does not require your consent to any provision of this document other than the certification to avoid backup withholding**.**

Name of Claimant *(Please print)*	Social Security Number
Sign Here Signature of Claimant or Authorized Representative	Date *(mm/dd/yyyy)*

If signed by Authorized Representative, describe your authority and provide documentation

(e.g., guardian, conservator, power of attorney, etc.)