Guide to Making your Claim

What you'll find in this packet

- **Initial Claim Form:** Use this form to begin your claim.
- **Medical Authorization**: This form allows us to get copies of your medical records. Please note that if your physician's office or treatment facility requires a separate form, please submit both forms with this packet.
- **Authorization for Disclosure of Information**: This form authorizes MetLife to release personal health information about your long-term care claim to another person(s).

To submit your claim, follow these steps:

1. Complete

Complete all forms in the **Initial Claim Packet**. Incomplete forms will delay our review.
***There are 4 areas that must be signed: 1) Section 7a, 2) Section 7b, 3) Medical Authorization *AKA* Authorization to release health information to MetLife 4) Authorization for Dislosure of Information.**
Submit all required documents with the form. If you are filling out this form for someone else, include a copy of any power of attorney or executorship paperwork.
Include a copy of the insured's photo ID with your documents.

2. Return

You can submit the completed packet by mail using the enclosed return envelope. Additionally, you can submit the completed packet to us by:
Fax: 1-859-825-6751
Email: LTC_BA_email@metlife.com

What to expect after you submit your claim

- Once we receive your Initial Claim Packet, MetLife will assign a care coordinator to review your claim.
- If we approve your claim, you will need to submit invoices that show proof of service and payment.

Please note that submitting the Initial Claim Packet is not a guarantee of benefits. We will determine benefit eligibility based on your coverage once we have obtained all of the information necessary to complete our review.

Medical Authorization

HIPAA: 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).

In connection with my application for a long-term care insurance policy, for underwriting and claim purposes, I authorize:

- any medical practitioner or facility or related entity; pharmacies and pharmacy-related services organizations; any insurer; any consumer reporting agency; employer; group policyholder, contract holder, or benefi t plan administrator and MIB Group, Inc. (MIB) to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
- personal information and data about me;
- the entire medical fi le for the last seven years, including medical information, records and data about me, including information such as office visits, outpatient treatment, drugs prescribed, medical test results and sexually transmitted diseases and similar information;
- information, records and data about me related to alcohol and drug abuse and treatment, including information, records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
- information, records and data about me relating to Acquired Immune Defi ciency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodefi ciency Virus (HIV) test results;
- information, records and data about me relating to mental illness, other than psychotherapy notes; and
- the company to request and obtain consumer reports.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that, unless permitted by applicable law, I cannot revoke this authorization: (1) to the extent that MetLife has taken action relying on the authorization; or (2) if MetLife obtained the authorization as a condition to my obtaining insurance coverage. In all other cases, I understand that I may revoke it at any time. To revoke the authorization, I must write to MetLife at MetLife HIPAA Authorizations, P.O. Box 990028, Hartford, CT 06199-0028 and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives my revocation will be valid. Revocation may be the basis for denying coverage or benefits. If I do not sign this Authorization, my application for long-term care insurance cannot be processed.

By signing below, I acknowledge my understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed and used by any reinsurer, employee, affi liate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information obtained pursuant to this authorization about me may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- I have a right to receive a copy of this form.

A copy of this form is as valid as the original form.

Claimant name	**Date of birth**

Sign Here	Signature of claimant or authorized representative	Date (mm/dd/yyyy)
	If an authorized representative signed above, please print full name of signee:	

MetLife

Privacy Authorization

Authorization for disclosure of information

Please print clearly and complete all sections.

Name:_____

Social Security Number:_____

I hereby authorize Metropolitan Life Insurance Company ("MetLife") to disclose my personal health information (including demographics, billing, and policy/plan information) about my Long-Term Care Insurance to the person(s) listed below to allow the person(s) to assist me in matters related to my insurance coverage. I understand that this authorization is voluntary.

Name	Relationship	Phone number

I understand that this authorization will expire 24 months from the date on this form or sooner if prescribed by law. I understand that I may revoke this authorization at any time by notifying MetLife in writing at the address in the enclosed letter, but if I do not revoke this authorization, it will not have any effect on any information released before MetLife received the revocation. I understand that refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits.

I understand that the person(s) listed above may re-disclose any information received. Once re-disclosed, the information may not be protected by applicable privacy laws.

Sign Here Signature of claimant or authorized representative

Date (mm/dd/yyyy)

If an authorized representative signed above, please print full name of signee:

MetLife

Initial claim for Long-Term Care insurance benefits

Things to know before you begin

- In the event you are completing this form for the covered person, "you" on this form refers to that individual.
- Submitting this completed form does not guarantee claim approval.
- Refer to the "Guide to making your claim" for additional information that must be submitted with this form.

Please complete this form as accurately as possible.

SECTION 1: Claimant's information

First name	Middle name	Last name

Social Security number	Date of birth *(mm/dd/yyyy)*	Marital status	Gender ☐ Male ☐ Female	Best time to call

Claimant's mailing address	City	State	ZIP

Facility name *(if applicable)*	Claimant's phone number

Do you have any other Long-Term Care insurance policies with MetLife or any other insurance carrier? If so, please identify the carrier:

Other Coverage Information

Is the Insured Person eligible for Medicare? ☐ Yes ☐ No

Is the Insured Person eligible for Medicaid? ☐ Yes ☐ No

Current location

Is your current location different from the primary residence you provided above? ☐ Yes ☐ No

(If yes, please complete the below information.)

Please indicate your current location.

☐ Family/Friends ☐ Assisted Living Facility ☐ Nursing Home

If you are currently living with Family/Friends, please identify the name of who you are living with:

How long have you lived with Family/Friends? _____

Street address	City	State	ZIP

Name of Nursing Home or Assisted Living Facility *(if applicable)*	Phone number

Where would you like correspondence sent? *(Check one)*

☐ Current location ☐ Claimant's address *(as listed in Section 1)* ☐ Primary contact *(listed in Section 2 below)*

SECTION 2: Primary contact information

Please provide information for the individual you have designated to be the primary point of contact.

Who is the primary contact for this claim? *(Check one)* ☐ Claimant ☐ Other *(If other, complete this section.)*

First name	Middle name	Last name

Street address	City	State	ZIP

Relationship to you	Phone number

Is the primary contact acting as an authorized representative for you? ☐ Yes ☐ No

If no, please provide the name of the authorized representative: _____

Please check the type of representation:

☐ Durable POA *(Medical& Financial)* ☐ Medical POA ☐ Financial POA ☐ Guardian ☐ Executor of estate ☐ Other

If you checked "other" above, please specify the type of representation: _____

Please note: The type of power of attorney will determine the authorization the designated person has on your behalf. For example, we cannot share specific policy information or act on instructions from the designated person with regard to this claim if he or she has a health care power of attorney *(referred to in some jurisdictions as a health care proxy)*. **We require a durable power of attorney in order to begin our evaluation of the claim, share information, or accept the representative's signature on forms related to this claim.**

SECTION 3: Claim information

Please provide a brief explanation of why claim is being filed *(for example, ailments, injuries, surgeries)*:

_____

_____

_____

Please indicate the reason(s) for filing this claim:

☐ Assistance performing daily living activities ☐ Supervision due to a cognitive impairment

Are you receiving long-term care services? ☐ Yes ☐ No

Have you previously received long-term care services? ☐ Yes ☐ No

Please indicate the date that long-term care services began, if applicable: _____

If you are expected to be discharged from a hospital, Skilled Nursing Facility, Intermediate Care Facility, or any other rehabilitation facility, please provide the expected discharge date/time frame, if known: _____

Please indicate the date you wish us to consider your eligibility for Long-Term Care benefits: _____

If long-term care services have not yet started, please indicate the expected start date: _____

Activities of daily living

Do you receive assistance from another individual with any of the following?

Bathing	☐ Yes ☐ No	If yes, how often?	
Dressing	☐ Yes ☐ No	If yes, how often?	
Transferring	☐ Yes ☐ No	If yes, how often?	
Eating	☐ Yes ☐ No	If yes, how often?	
Toileting	☐ Yes ☐ No	If yes, how often?	
Bladder Continence	☐ Yes ☐ No	If yes, how often?	
Bowel Continence	☐ Yes ☐ No	If yes, how often?	
Ambulation	☐ Yes ☐ No	If yes, how often?	

Cognitive status *(Please check your response)*

Do you have a formal diagnosis of a cognitive impairment? If known, please include the physician's contact information that provided diagnoses in Section 4. ☐ Yes ☐ No

What was the diagnosis? _____

When was the diagnosis? _____

Have you received any cognitive testing? If yes, please provide the name of the physician's contact information that performed the cognitive testing in Section 4. ☐ Yes ☐ No

SECTION 4: Medical provider information

Please list all physicians who have treated you within the last 2 years *(attach extra sheet, if necessary).*

Physician information

First name	Middle name	Last name	
Street address	City	State	ZIP
Phone number	Fax number	Date of first visit	Date of last visit

Specialty: _____

First name | Middle name | Last name

Street address | City | State | ZIP

Phone number | Fax number | Date of first visit | Date of last visit

Specialty: _____

First name | Middle name | Last name

Street address | City | State | ZIP

Phone number | Fax number | Date of first visit | Date of last visit

Specialty: _____

First name | Middle name | Last name

Street address | City | State | ZIP

Phone number | Fax number | Date of first visit | Date of last visit

Specialty: _____

Hospital/Acute rehabilitation confinement information

Please list all hospital/acute rehabilitation confinement within the last 2 years *(attach extra sheet, if necessary).*

Hospital | Phone number | Fax number

Street address | City | State | ZIP

Treatment dates: _____

Hospital | Phone number | Fax number

Street address | City | State | ZIP

Treatment dates: _____

Hospital	Phone number	Fax number

Street address	City	State	ZIP

Treatment dates: _____

SECTION 5: Long-Term Care provider information

For each Long-Term Care provider involved in this claim, please provide the following information *(attach extra sheets, if necessary).*

Long-Term Care provider name	Contact name *(if any)*

Street address	City	State	ZIP

Phone number	Tax ID number/License *(if known)*

Fax number	Start of care date *(mm/dd/yyyy)*	End of care *(if applicable)*	Frequency of care

Type *(indicate one)*		Payment *(indicate one)*
☐ Nursing Home/Skilled Nursing Facility	☐ Hospice	☐ Medicare
☐ Assisted Living Facility	☐ Adult Day Care	☐ Medicaid
☐ In-home therapy or skilled nursing	☐ Home Care Agency	☐ Veterans Affair
☐ Unlicensed Independent Caregiver		
☐ Licensed Independent Caregiver	☐ Other *(please specify)*: _____	☐ Other *(please specify)*: _____

Rate of Pay $ _____ ☐ Hour ☐ Day ☐ Month

Long-Term Care provider name	Contact name *(if any)*

Street address	City	State	ZIP

Phone number	Tax ID number/License *(if known)*

Fax number	Start of care date *(mm/dd/yyyy)*	End of care *(if applicable)*	Frequency of care

Type *(indicate one)*

- ☐ Nursing Home/Skilled Nursing Facility
- ☐ Assisted Living Facility
- ☐ In-home therapy or skilled nursing
- ☐ Unlicensed Independent Caregiver
- ☐ Licensed Independent Caregiver
- ☐ Hospice
- ☐ Adult Day Care
- ☐ Home Care Agency
- ☐ Other *(please specify)*: _____

Payment *(indicate one)*

- ☐ Medicare
- ☐ Medicaid
- ☐ Veterans Affair
- ☐ Other *(please specify)*: _____

Rate of Pay $ _____ ☐ Hour ☐ Day ☐ Month

Long-Term Care provider name | Contact name *(if any)*

Street address | City | State | ZIP

Phone number | Tax ID number/License *(if known)*

Fax number | Start of care date *(mm/dd/yyyy)* | End of care *(if applicable)* | Frequency of care

Type *(indicate one)*

- ☐ Nursing Home/Skilled Nursing Facility
- ☐ Assisted Living Facility
- ☐ In-home therapy or skilled nursing
- ☐ Unlicensed Independent Caregiver
- ☐ Licensed Independent Caregiver
- ☐ Hospice
- ☐ Adult Day Care
- ☐ Home Care Agency
- ☐ Other *(please specify)*: _____

Payment *(indicate one)*

- ☐ Medicare
- ☐ Medicaid
- ☐ Veterans Affair
- ☐ Other *(please specify)*: _____

Rate of Pay $ _____ ☐ Hour ☐ Day ☐ Month

Long-Term Care provider name | Contact name *(if any)*

Street address | City | State | ZIP

Phone number | Tax ID number/License *(if known)*

Fax number | Start of care date *(mm/dd/yyyy)* | End of care *(if applicable)* | Frequency of care

Type *(indicate one)*		Payment *(indicate one)*
☐ Nursing Home/Skilled Nursing Facility	☐ Hospice	☐ Medicare
☐ Assisted Living Facility	☐ Adult Day Care	☐ Medicaid
☐ In-home therapy or skilled nursing	☐ Home Care Agency	☐ Veterans Affair
☐ Unlicensed Independent Caregiver		
☐ Licensed Independent Caregiver	☐ Other *(please specify)*: _____	☐ Other *(please specify)*: _____

Rate of Pay $ _____ ☐ Hour ☐ Day ☐ Month

If you indicated that Long-Term Care services are paid for by Medicaid, please provide the contact name and phone number of the Medicaid case worker.

Name	Phone number

SECTION 6: Payment authorization

If claim for benefits is approved, I authorize MetLife to pay:

☐ Claimant ☐ Claimant's Estate *(if deceased)*

☐ Facilities or Home Care Agencies named above- *enter name(s)*: _____

SECTION 7a: Certification and signature

Before signing below, I certify that the statements and information contained on this claim form are true and correct to the best of my knowledge and belief. Further, 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.

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.

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.

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

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.

First name | Middle name | Last name

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

SECTION 7b: Certification and signature

Under penalties of perjury, I certify that:

1. The number shown on this form as my Social Security Number Tax Identification Number is my correct taxpayer identification number, and
2. 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 *(If you have been notified by the IRS that you are currently subject to backup withholding because of under reporting interest or dividends on your tax return, you must cross out and initial this item.)*
3. I am a U.S. citizen 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. *(If you are not a U.S. Citizen or other U.S. person for tax purposes, please cross out the last two certifications and complete appropriate IRS documentation.)*

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

First name | Middle name | Last name

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