Group Accident Insurance Claim Form

Metropolitan Life Insurance Company

Important Instructions for Requesting Accident Benefits

- If this is an Initial Claim for an accident, please complete each section in its entirety. *(An accident is not considered reported to us until a claim form is received).*
- If this is an additional claim for an accident previously reported *(i.e. - initial claim previously submitted and additional services were incurred)*, no claim form is required. Please provide itemized bills or treatment notes for the additional services. Include your claim number and/or certificate number on all pages of your submission.
- Please provide supporting documentation from the healthcare provider related to the injuries and services received for which a claim is being made. The supporting documents MUST include 1) patient's name, 2) service dates, 3) diagnosis, 4) specific procedure or treatment.
- Documentation that might be helpful to MetLife in making a claim decision includes the following items: Itemized invoices received for services as a result of this accident. You may need to ask your healthcare provider to provide you with a UB-04 form or other documentation. If you have an Explanation of Benefits (EOB), please also include this documentation.
- If treated in an emergency room, please provide a copy of the discharge papers from the hospital.
- If treated in an emergency room, please provide a copy of the discharge papers from the hospital.
- If admitted to a hospital, provide documentation from the hospital that details admission and discharge dates, diagnosis and room assignment *(ICU and/or Non ICU)*.
- If you were tested for alcohol or drugs in connection with an accident or injury please provide a copy of the drug screening or blood alcohol report.
- If the injury was the result of a motor vehicle accident, please provide a copy of the motor vehicle accident report.
- If the patient is deceased, we will need a copy of the death certificate.
- You must sign and submit the **Authorization to Disclose Health Information** form *(attached)*.
- Please refer to your certificate of insurance for a listing of specific benefits covered under your plan.

Failure to complete all sections of this claim form may delay processing this claim. To prevent possible delays, please be sure to provide all documentation from your healthcare provider that supports this claim. You will be notified in writing if additional information is needed to process your claim.

SECTION 1: Certificateholder Information *(Participant)*

Certificateholder name - First	Middle initial	Last name

Address - Street	City	State	Zip code

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

Cell phone number	Daytime phone number	Evening phone number	EMAIL address *(optional)*

Employer name

SECTION 2: Patient Information

☐ Same as Section 1 *(If you check this box, you do not need to complete this section. You may skip to Section 3.)*

☐ Spouse ☐ Child

Patient name - First	Middle initial	Last name

Home address - Street	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

SECTION 3: Accident Details

Please provide the following accident claim details.

Date of accident *(mm/dd/yyyy)*	Where did the accident occur?

City where accident occurred	State where accident occurred

Describe how the accident occurred. Describe what you were doing and how you were injured *(Include additional information on a separate sheet of paper if needed.)*

Was this a motor vehicle accident? ☐ Yes *(Attach the police report.)* ☐ No

Was the patient involved in any other type of accident that required a police report? ☐ Yes *(Attach the police report.)* ☐ No

Did the accident occur at work? ☐ Yes *(Attach a copy of report of the injury filed with your employer.)* ☐ No

Primary Care Provider Information

First name	Middle initial	Last name

Address - Street	City	State	Zip code

Phone number

Please provide the following information for all doctors and hospitals that have treated you for your accident/injury

Physician/Provider/ Facility name	Phone number

Address - Street	City	State	Zip code

Dates consulted

If applicable, date of hospital admission *(mm/dd/yyyy)*	Hospital discharge date *(mm/dd/yyyy)*

Physician/Provider/ Facility name	Phone number

Address - Street	City	State	Zip code

Dates consulted

If applicable, date of hospital admission *(mm/dd/yyyy)*	Hospital discharge date *(mm/dd/yyyy)*

SECTION 4: Additional Details

Was a Ground Ambulance service used? ☐ Yes ☐ No

If Yes, provide the date ground ambulance transportation occurred, billing invoices, and all supporting documentation for receipt of this service. *(mm/dd/yyyy)*

Was an Air Ambulance service used? ☐ Yes ☐ No

If Yes, provide the date air ambulance transportation occurred, billing invoices, and all supporting documentation for receipt of this service. *(mm/dd/yyyy)*

If applicable, did the patient's companion stay at a lodging that meets the Lodging Benefit requirements?

☐ Yes ☐ No

If Yes, provide the lodging checkout receipt. *(mm/dd/yyyy)*

SECTION 5: 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

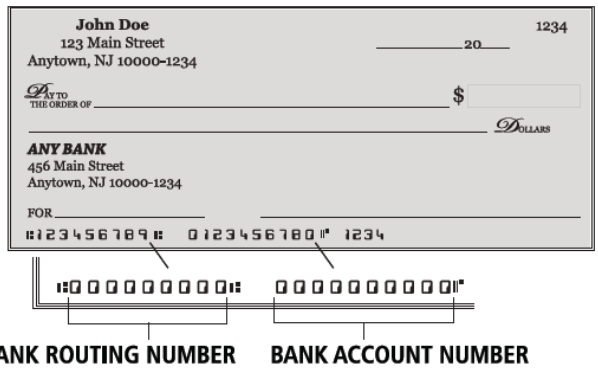
Bank street address	City	State	Zip code

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

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

Bank routing number

Bank account number



Authorization & Signature of Certificateholder

- I request MetLife to send my payments to the financial institution designated in Section 5 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)*

Sign Here Certificateholder Signature

Date *(mm/dd/yyyy)*

Next steps:

- Review and complete the Fraud Warnings, Certification & Signature sections.
- Review and complete the Authorization to Disclose Health Information Page.