Hospital Indemnity Insurance Claim Form

MetLife

Things to know before you begin

- If you are submitting a claim for a Hospitalization which you have not yet reported to us, please complete this claim form. Once we receive a completed claim form we consider this Hospitalization to have been reported to us.
- If you are submitting a claim for a Hospitalization which you have already reported to us (you have already submitted a completed claim form to us), an additional claim form is not required. Include the claim number assigned to the Hospitalization at the top of all documentation that you are submitting to us in support of a claim that has previously been reported. Fax or mail any additional documentation related to a claim to the address/fax number located in the top right corner of this form.
- Anytime you are submitting a claim to us, please provide us with supporting documents from the provider related to the Hospitalization for which a claim is being made. The supporting documents must include: 1) an admission summary; 2) a discharge summary; and 3) the date(s) of service.

Metropolitan Life Insurance Company
Attn: Hospital Indemnity Insurance Product
P.O. Box 80826
Lincoln, NE 68501-0826

Toll Free Phone:
1 800 GET MET 8 (1 800 438 6388)

Fax Number: 1 855 306 7350

Please complete Sections 1 through 4. Review, sign and date pages 5 and 6. Return completed form by fax or mail.

Complete Section 7A on the Physician's attachment. Your physician must complete the remainder of the Physician's attachment (Section 7B and 7C) and return the completed form by fax of mail.

Supply information about the certificateholder.

SECTION 1 - Certificateholder Information

Certificateholder Name *(First, Middle Initial, Last Name)*			Certificate Number

Address - Street

City	State	Zip Code

Date of Birth *(Month/Day/Year)*	Gender	Social Security Number
	☐ Male ☐ Female	

Cell Phone Number	Daytime Phone Number	Evening Phone Number

EMAIL Address *(optional)*	Employer Name

Supply information about the patient.

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 *(Month/Day/Year)* | Gender ☐ Male ☐ Female | Social Security Number

Cell Phone Number | Daytime Phone Number | Evening Phone Number

Provide hospitalization details.

SECTION 3: Hospitalization Details

Refer to your group certificate or Summary Plan Description for a complete description of your benefits. Not all plans contain the same benefits.

Admission Date *(Month/Day/Year)* | Discharge Date *(Month/Day/Year)*

Hospital Name

City | State

Are you claiming for a Lodging Benefit? ☐ Yes ☐ No *(If Yes, please submit the hotel receipt(s).)*

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

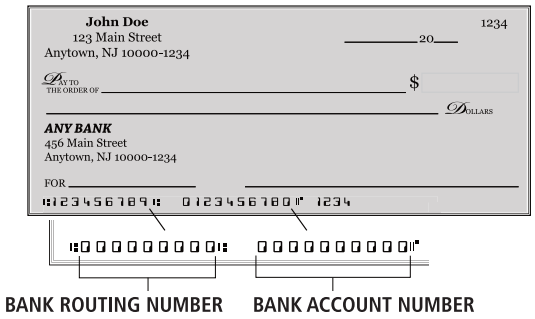
City	State	Zip Code

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

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.
- Provide the Physician's Attachment and completed Authorization to Disclose Health Information Page to your treating Physician for completion.

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: A 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, Virginia 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 false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 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 and 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.

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.

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 & 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. 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 penalty of perjury, I certify:

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.

Signature of Insured or Authorized Representative | Date *(Month/Day/Year)*

Name of Insured or Authorized Representative, if applicable *(First Name, Middle Initial, Last Name) (Please Print)*

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

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

Authorization to Disclose Health Information

MetLife

Things to know before you begin

- **Instructions for completing the form: complete all applicable areas of the form; sign this form; provide a copy along with the Physician's Attachment to your physician.**
- **If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf.**

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Your refusal to complete and sign this form may affect your eligibility for benefits under your hospital indemnity insurance policy.

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).

For purposes of determining my eligibility for hospital indemnity benefits, the administration of my hospital indemnity plan, and the administration of other benefit plans in which I participate that may be affected by my eligibility for hospital indemnity benefits, I permit the following disclosures of information about me to be made in the format requested, including by telephone, fax or mail:

1. **I permit:** any physician or other medical/treating practitioner, hospital, clinic, other medical related facility or service, insurer, employer, government agency, group policyholder, contractholder or benefit plan administrator to disclose to Metropolitan Life Insurance Company ("MetLife"), my employer in its capacity as administrator of its hospital indemnity plan, and any consumer reporting agencies, investigative agencies, attorneys, and independent claim administrators acting on MetLife's behalf, any and all information about my health, medical care, employment, and hospital indemnity claim.
2. **I permit** MetLife and my employer (if applicable) to disclose in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and hospital indemnity claim.

This Authorization to Disclose Health Information specifically includes my permission to disclose my entire medical record, including medical information, records, test results, and data on: medical care or surgery; psychiatric or psychological medical records, but not psychotherapy notes; and alcohol or drug abuse including any data protected by Federal Regulations 42 CFR Part 2 or other applicable laws. Information concerning mental illness, HIV, AIDS, HIV related illnesses and sexually transmitted diseases or other serious communicable illnesses may be controlled by various laws and regulations. I consent to disclosure of such information, but only in accordance with laws and regulations as they apply to me. Information that may have been subject to privacy rules of the U.S. Department of Health and Human Services, once disclosed, may be subject to redisclosure by the recipient as permitted or required by law and may no longer be covered by those rules. Your health care provider may not condition your treatment on whether you sign this authorization.

I understand that I may revoke this authorization at any time by writing to MetLife Hospital Indemnity at P.O. Box 80826, Lincoln, NE 68501-0826, except to the extent that action has been taken in reliance on it. If I do not, it will be valid for 24 months from the date I sign this form or the duration of my claim for benefits, whichever period is shorter. A photocopy of this authorization is as valid as the original form and I have a right to receive a copy upon request.

Name of Claimant or Authorized Representative *(Please Print) (First, MI, Last)*

Date of Birth *(Month/Day/Year)*

Signature of Claimant or Authorized Representative

Date *(Month/Day/Year)*

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

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

MetLife

Hospital Indemnity Insurance Claim – Physician Statement

Things to know before you begin

- The patient submitting this Hospitalization Claim must complete Section 7A before giving it to a physician.
- Any fee charged by the physician for completing this form is the patient's responsibility.
- The physician must sign Section 7C after completing the claim form.
- The physician must return the completed claim form and any attachments by fax or by mail to the address listed in the header of the claim form or directly to the patient.
- If you have questions, please call 1 800 GET MET 8.

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Patient: please complete Section 7A. Physician: you must complete the rest of the Physician's Attachment. Return completed form by fax or mail.

The patient must complete this section.

SECTION 7A: About the Patient

Patient Name *(First, Middle Initial, Last Name)* | Date of Birth *(Month/Day/Year)*

Employer Name your coverage is with

Physician Name *(First, Middle Initial, Last Name)* | Physician phone

I authorize the release of any medical information necessary to process this claim.

Patient signature | Date *(Month/Day/Year)*

Authorized Representative *(e.g., guardian, conservator, power of attorney, etc.)* | Date *(Month/Day/Year)*

The Physician must complete all of Section 2.

SECTION 7B: Hospital Benefits

Supporting documents related to the hospitalization of your patient reported to us in this claim form should include:

- the diagnosis
- the admission and discharge dates
- hospital admission and discharge summaries

The term Intensive Care Unit (ICU) includes Hospital units with the following names:
Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Pulmonary Care Unit; Burn Unit; or Transplant Unit.

1. What type of Hospitalization did your patient require?

☐ **Non ICU Hospital benefits**

Date your patient was admitted to a Non ICU unit of the Hospital

Name of Facility | Admission Date *(Month/Day/Year)*

Date your patient was discharged from the Non ICU unit of the Hospital

Discharge Date *(Month/Day/Year)*

☐ **ICU Hospital benefits**

Date your patient was admitted to an ICU unit of the Hospital

Name of Facility | Admission Date *(Month/Day/Year)*

Date your patient was discharged from the ICU unit of the Hospital

Name of Facility | Discharge Date *(Month/Day/Year)*

2. Did the patient ever consult you before? ☐ Yes ☐ No
(If yes, what was the diagnosis and the date you provided treatment for the illness.)

Date(s) treatment provided

Diagnosis that required treatment

SECTION 7C: Medical Provider Signature

Signature of Physician | Date signed *(Month/Day/Year)*

Name of Facility | Phone Number

Address - Street | City | State | Zip Code