METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK EMPLOYEE
STATEMENT OF CLAIM
FOR
ACCIDENT AND SICKNESS WEEKLY BENEFITS

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40512
Fax: 1-800-230-9531

TO BE COMPLETED BY THE EMPLOYEE

(Please answer all questions)

1. Your name *(Print)* _____ Phone No. _____
(Include area code)

2. Present address: No. _____ Street _____ City _____ State _____ Zip Code _____

☐ Male ☐ Female Date of birth mm/dd/yy ☐ Single ☐ Married Social Security No. ☐☐☐☐☐☐☐☐☐

3. Date you were first disabled by this sickness or injury mm/dd/yy

4. If you were hospitalized as a bed patient, please answer the following:

(a) Name and Address of Hospital _____

(b) Date Admitted mm/dd/yy at hh:mm *(Hour)* { a.m. p.m. *(c)* Date Discharged mm/dd/yy at hh:mm *(Hour)* { a.m. p.m.

5. Was an accident involved? ☐ Yes ☐ No If "Yes please answer the following:

(a) When did the accident happen? Date mm/dd/yy at hh:mm *(Hour)* { a.m. p.m.

(b) Where did the accident happen? City _____ State _____

(c) Were you at work when the accident happened? ☐ Yes ☐ No

(d) Give a brief description of the accident _____

I hereby authorize the Health Care Provider to release any information requested with respect to this claim.
I certify that the information furnished by me in support of this claim is true and correct.
Any person who knowingly and with intent to defraud any insurance company 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 and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Date mm/dd/yy Signed _____
(Insured Employee)

TO BE COMPLETED BY THE EMPLOYER

(Please answer all questions)

1. Employee's name _____ Social Security No. ☐☐☐☐☐☐☐☐☐

Date of Hire mm/dd/yy Current Occupation _____ Job Title _____

Premium Contributions:

Employer _____ % Employee _____ % ☐ Pre-Tax ☐ Post-Tax

2. Basic Earnings: $ _____ ☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

If earnings are variable, provide the last eight (8) weeks of earnings prior to the week in which the disability commenced:

$ _____
$ _____
$ _____
$ _____
$ _____
$ _____
$ _____
$ _____

Average Hours Worked Per Week: _____ Effective Date of Employee's Insurance mm/dd/yy

3. If the employee was not actively in your employ when this disability began, indicate below the reason for stopping work

☐ Laid off ☐ On leave of absence ☐ Discharged or resigned ☐ Other _____
(Please explain)

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4. If this employee's coverage has been canceled, give the date and reason mm/dd/yy _____

5. If salary continued, give date salary paid through mm/dd/yy _____

6. *(a)* Date last worked mm/dd/yy _____ *(b)* Date returned to work mm/dd/yy _____

7. Is the employee claiming or receiving Workers' Compensation Benefits? ☐ Yes ☐ No

If 'Yes,' what is the present status of the compensation claim? _____

8. Give any information which might assist the Company in the consideration of this claim _____

_____

Employer Name: _____

Report Number: _____ Subdivision: _____ Branch: _____

Authorized Representative: _____ _____

name title

Date mm/dd/yy _____ Telephone Number *(include area code)*: _____

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR *(4)* WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLAIM FORM DB-300.

--- HEALTH CARE PROVIDER'S STATEMENT *(Please Print or Type)*

The Health Care Provider's statement must be filled in completely and the form mailed to the insurance carrier or self-insured employer, or returned to the claimant within seven days of the receipt of the form. For item 7-D, give approximate date. Make some estimate. If disability is caused by or arising in connections with pregnancy, enter estimated delivery date under "Remarks."

1. Claimant's Name _____ (First / Middle / Last) **2.** Age _____

3. Sex ☐ Male ☐ Female

4. Diagnosis/Analysis: _____ Diagnosis Code: _____

a. Claimant's Symptoms: _____

b. Objective Findings: _____

5. Claimant Hospitalized? ☐ Yes ☐ No From _____ To _____

6. Operation Indicated? ☐ Yes ☐ No a. Type _____ b. Date mm/dd/yy

7. Enter Dates for the following:

	Mo.	Day	Year
(a) Date of your first treatment for this disability			
(b) Date of your most recent treatment for this disability			
(c) Date Claimant was unable to work because of this disability			
(d) Date Claimant will be able to perform usual work			

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No

If yes, has Form C-4 been filed with the Workers' Compensation Board? ☐ Yes ☐ No

Remarks *(Attach additional sheet, if necessary)*: _____

(If disability is pregnancy related, please enter estimated delivery date.)

I affirm that I am a				Licensed in the state of	License Number
☐ Chiropractor	☐ Physician	☐ Psychologist			
☐ Dentist	☐ Podiatrist	☐ Nurse-Midwife			

Health Care Provider's Signature _____ Date mm/dd/yy

Health Care Provider's Name *(Please Print)* _____ Tel No. _____

Office Address _____ (Number / Street / City or Town / State / Zip)

IF YOU HAVE ANY QUESTIONS ABOUT CLAIMING DISABILITY BENEFITS, CONTACT THE NEAREST OFFICE OF THE NYS WORKERS' COMPENSATION BOARD, OR WRITE TO WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, N.Y. 12241-0005

SI TIENE DUDAS RELACIONADAS CON LA RECLAMACIÓN DE BENEFICIOS POR INCAPACIDAD, COMUNIQUESE CON LA OFICINA MAS CERCANA DE LA JUNTA DE COMPENSACIÓN OBRERA DE NUEVA YORK, O ESCRIBA A: WORKERS' COMPENSATION BOARD, DISABILITY BENEFITS BUREAU, 100 BROADWAY-MENANDS, ALBANY, NY 12241-0005

★ ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

FOR USE BY METROPOLITAN LIFE INSURANCE COMPANY

DIAG. CODE		THR. DATE	CALL-UP WEEKS	DAYS WORKED	ACC.	LETTER NO.	DISP.	SUPR.	CTL.		APPR NO.	DATE OF REVIEW
1					Yes ☐							
2					No ☐							
3					Auto ☐							

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