Statement of claim for Accidental Death and Dismemberment benefits

Metropolitan Life Insurance Company

To the employer

When this form should be completed

You should **always** complete this form when the insured or covered dependent suffers an accidental injury that results in a covered loss other than death. Completion of a separate life insurance claim form is not necessary.

Instructions

1. Complete the **Employer's Statement** and provide the entire form to the claimant.
2. Instruct the claimant to complete the **Claimant's Statement** and submit the entire form, plus any additional documents and forms, such as the **Attending Physician Statement**, to MetLife.
3. Contact MetLife if you have further questions.

To the claimant

To ensure that you have knowledge of all Accidental Death and Dismemberment (AD&D) benefits that are included in your life insurance plan, this claim form is being provided to you.

Your employer should complete the **Employer's Statement**. The description of benefits below provides a list of benefits that are available under your AD&D benefit.

To file a claim for AD&D benefits, complete the **Claimant's Statement**. Your claim may also require your physician to complete an **Attending Physician's Statement**.

Upon completion, send all parts of the form to MetLife.

Mail:
MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505

Fax:
570.558.8645

If you have questions, call 800.638.6420.

Upon receipt, your claim will be thoroughly reviewed. It may be necessary for MetLife to request additional information before a final determination is made.

Description of benefits

If the insured suffers an accident and meets the conditions for any of the benefits listed below, an accidental death and dismemberment benefit may be payable.

- Limb/digit amputation
- Entire and irrevocable loss of hearing in both ears
- Entire and irrevocable loss of speech
- Permanent and uncorrectable loss of vision in one or both eyes
- Complete, permanent and irreversible paralysis
- Rehabilitative physical therapy

MetLife

Employer statement of claim for Accidental Death and Dismemberment benefits

Metropolitan Life Insurance Company

SECTION 1: Employer's statement *(To be completed by the employer; please answer all questions)*

Insured employee - First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	Social Security number	☐ Male ☐ Female
Date of accident *(mm/dd/yyyy)*	Date of loss *(if applicable)*	Date of hire *(mm/dd/yyyy)*
Base annual earnings		As of date *(mm/dd/yyyy)*

Employee is: ☐ Hourly or ☐ Salaried
☐ Exempt or ☐ Non-Exempt

Was insurance ever assigned? ☐ Yes ☐ No
(If yes, please attach a copy of assignment and all related papers)

Insurance type	Amount	Report number	Sub/Div.	Branch/class
Employee's full amount of Basic AD&D insurance	$	200880	1.00	
Employee's full amount of Optional AD&D insurance	$	200882	1.00	
Employee's full amount of Dependent Life-Spouse AD&D insurance	$	200885	1.00	

☐ Active employee | Effective date of amount claimed

If the employee was not actively at work on the date of loss, please indicate status:

☐ Terminated for any other reason
☐ Terminated due to disability
☐ Leave of absence/layoff/sick leave
☐ Disabled *(Not terminated or retired)*

What was the last date the employee was physically doing work? | Reason for stopping

Date premium payments for employee stopped | Was life insurance cancelled? ☐ Yes ☐ No | Date *(mm/dd/yyyy)*

Was the employer/employee relationship terminated before the loss? ☐ Yes ☐ No | Date *(mm/dd/yyyy)* | Reason

Was a total and permanent disability or continued protection disability waiver claim ever filed with MetLife for this employee? ☐ Yes ☐ No | Disability case number

SECTION 2: Dependent claim only

Date of loss *(mm/dd/yyyy)*	Date of birth *(mm/dd/yyyy)*	Dependent Social Security number

Relationship *(Spouse)*

☐ Male
☐ Female

Name of dependent

First name	Middle name	Last name

Address	City	State	Zip code

SECTION 3: Signature

Employer name	Phone number

Address	City	State	Zip code

First name	Middle name	Last name

Sign Here Signature of employer representative

Date *(mm/dd/yyyy)*

Metropolitan Life Insurance Company

Your Accidental Death and Dismemberment benefit claim kit

The following documents are included in your Accidental Death and Dismemberment benefit claim kit:

- *Claimant statement of claim for Accidental Death and Dismemberment benefits*;
- *Attending physician's statement of claim for Accidental Death and Dismemberment benefits*;
- *About the Total Control Account* document; and
- *Fraud warnings* document.

To ensure that you have knowledge of all Accidental Death and Dismemberment (AD&D) benefits that are included in your life insurance plan, this claim form is being provided to you.

Your employer should complete the **Employer's Statement**. The description of benefits below provides a list of benefits that are available under your AD&D benefit.

To file a claim for AD&D benefits, complete the **Claimant's Statement**. Your claim may also require your physician to complete an **Attending Physician's Statement**.

Upon completion, send all parts of the form to MetLife.

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MetLife
Group Life Claims
P.O. Box 6100
Scranton, PA 18505

Fax:
570.558.8645

Upon receipt, your claim will be thoroughly reviewed. It may be necessary for MetLife to request additional information before a final determination is made.

Description of benefits

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- Entire and irrevocable loss of speech
- Permanent and uncorrectable loss of vision in one or both eyes
- Complete, permanent and irreversible paralysis
- Rehabilitative physical therapy

Paying your claim

Our standard method of paying the proceeds of your claim is to deposit them into a convenient Total Control Account. You'll find more details in the enclosed document, *About the Total Control Account.*

We're here to help

We recognize this may be a challenging time for you. If you have questions or need help preparing your claim, call us at **800.MET.6420 (800.638.6420)**. Our Customer Service Center is open Monday through Thursday, 8 a.m. to 8 p.m. EST, and Friday 8 a.m. to 5 p.m. EST.

Sincerely,

MetLife
U.S. Life Insurance Claims

MetLife

Claimant statement of claim for Accidental Death and Dismemberment benefits

PEBA SC Retirement Systems and State Health Plan

Metropolitan Life Insurance Company

Section 1: Claimant's statement *(To be completed by the claimant)*

Information about the insured employee: *(Do not complete this section if you are the claimant as well as the insured)*

Insured employee - First name	Middle name	Last name

Employer name

Address	City	State	Zip code

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Section 2: Information about you

First name	Middle name	Last name

Social Security number	Date of birth *(mm/dd/yyyy)*	Daytime phone number	Evening phone number

Address	City	State	Zip code

Relationship to the insured ☐ Spouse ☐ Self

When did the accident happen? Date *(mm/dd/yyyy)* _____ at Hour _____ ☐ a.m. ☐ p.m.

Where did the accident happen? City _____ State _____

Give a brief description of the accident.

_____

_____

_____

Total Control Account

Our standard payment method is the **Total Control Account**. A check will be issued to you if required by state law, regulation or direction.

Learn about the Total Control Account in the *About Total Control Account* document you were provided.

Check here is you want to receive a check. ☐

Insured employee - First name	Middle name	Last name

Insured's employer's name

Section 3: Certifications and 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. Any contributions owed by the insured will be deducted from insurance proceeds paid to me.
3. I have read the applicable Fraud Warning(s) provided. **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 the claim for each such violation.

Under penalty of perjury, I certify:

1. **The number shown as my Social Security number or Tax Identification number in *Section 2: Information about you* is my correct number;**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, (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;**
3. **I am a U.S. citizen, resident alien 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.**

(Please note: You must cross out Item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest or dividend income on your tax return.)

** If you are not a U.S. Citizen, a U.S. resident alien or other U.S. person for tax purposes, please cross out Items 3 and 4 above, and complete and submit IRS form W-8BEN (individuals) or W-8BEN-E (entities).*

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

Please sign below. If the beneficiary is a minor, the legal guardian or adult submitting this form must sign, not the minor. If no legal guardian is appointed to handle the minor's estate, a responsible adult should complete and sign the claimant statement on behalf of the minor beneficiary. If a legal guardian of the minor child's estate has been or will be appointed, the guardian must complete and sign the claimant statement. Be sure to include a copy of the court-issued guardianship papers in the claim submission to MetLife.

Sign Here	Signature of claimant	Date *(mm/dd/yyyy)*

MetLife

Attending Physician's statement of claim for Accidental Death and Dismemberment benefits

PEBA SC Retirement Systems and State Health Plan

Metropolitan Life Insurance Company

Insured employee - First name	Middle name	Last name

Insured's employer's name

SECTION 1: Attending physician's statement

Patient - First name	Middle name	Last name

Age	Date first consulted on account of the injury described *(mm/dd/yyyy)*

Date of accident causing present loss *(mm/dd/yyyy)*	Date of last treatment for this condition *(mm/dd/yyyy)*

Describe the exact nature, location and extent of all injuries sustained.

Was the injury described solely responsible for the loss? ☐ Yes ☐ No

If not, provide more information about any contributing cause or causes.

Provide names of any other physicians who treated the patient for a contributory condition and the dates of their first and last treatments as reported to you.

In your opinion, was the loss caused in any way by illness? ☐ Yes ☐ No

If yes, what was the date you provided treatment for the illness?

Insured employee - First name	Middle name	Last name

Insured's employer's name

Did the patient ever consult you before? ☐ Yes ☐ No

If yes, please state the dates and the ailments for which you attended, treated or examined the patient.

Complete the applicable section below for the benefit being claimed.

SECTION 2: To be completed only for limb/digit amputations

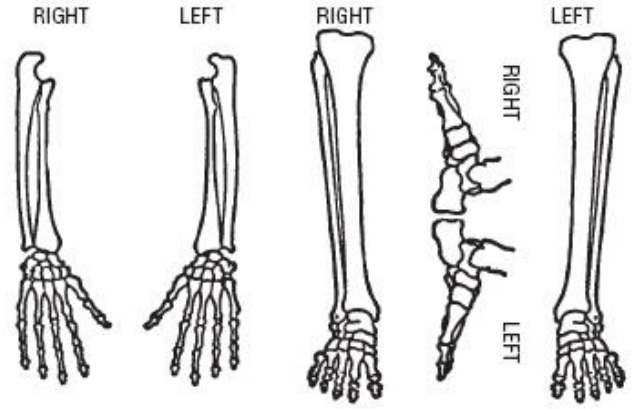
What limb/digit was severed or amputated?

State the dates on which the severance or amputation occurred.

State the cause of the amputation.

If the limb/digit was reattached, indicate date of reattachment and functional outcome.

State the exact point at which the amputation was performed or the severance occurred with respect to each limb/digit lost. If the severance or amputation was below the elbow or knee joint, indicate on the chart the exact point of severance.



Insured employee - First name	Middle name	Last name

Insured's employer's name

Attending physician - First name	Middle name	Last name	
Address	City	State	Zip code
Name of facility		Phone number	
Sign Here Signature of attending physician		Date *(mm/dd/yyyy)*	

SECTION 3: To be completed only for loss of vision

Has the patient had entire and irrecoverable loss of sight following the injury? ☐ Yes ☐ No

If yes, please answer the following:

Date you first determined vision was irrecoverably reduced to 20/200 *(Snellen Notation)* or less with correction and the vision remaining in each eye. Date *(mm/dd/yyyy)* _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

Date and vision found on last eye examination. Date *(mm/dd/yyyy)* _____

	Uncorrected	Corrected
O.D.v.		
O.S.v.		

(Snellen Notations)

State the cause of loss of vision.

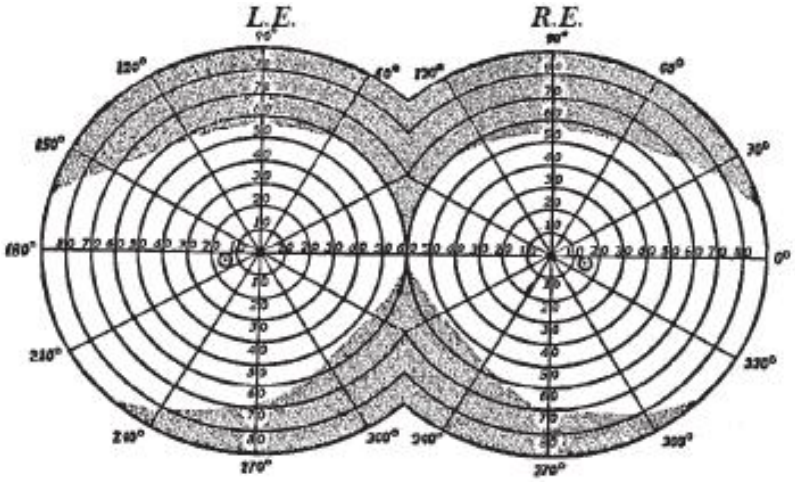
Indicate whether recovery or useful vision is possible by operation or treatment.

O.D.	☐ Operation	☐ Treatment
O.S.	☐ Operation	☐ Treatment

Insured employee - First name	Middle name	Last name

Insured's employer's name

If fields of vision are contracted, show contraction on chart below.



SECTION 4: To be completed only for rehabilitative physical therapy

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* _____

Did you prescribe rehabilitative physical therapy for the patient as a consequence of the loss? ☐ Yes ☐ No

Date therapy prescribed *(mm/dd/yyyy)* _____

Name of facility			Phone number
Address	City	State	Zip code
Attending physician - First name	Middle name	Last name	
Sign Here Signature of attending physician			Date *(mm/dd/yyyy)*

SECTION 5: To be completed only for paralysis

Date you first determined paralysis was permanent, complete and irreversible, etiology of the paralysis, method of correction and result.

Date *(mm/dd/yyyy)*	Etiology

State the specific limb(s) paralyzed.

Insured employee - First name	Middle name	Last name

Insured's employer's name

State the location of lesion(s) responsible.

State the type of lesion(s) responsible.

State the test results which document paralysis. *(i.e., physical exam, EMG, nerve conduction tests)*

State the method of correction.

State the functional result of correction.

SECTION 6: To be completed only for loss of speech

State the duration in months of patient's entire and irrecoverable loss of speech following the injury.

Date you first determined speech was irrecoverably lost and the specific etiology for absence of speech *(vocalization)*, method and results of correction. Date *(mm/dd/yyyy)* _____

Specify basis for speech loss:

	Description uncorrected	Corrected method
Absence of vocalization structure(s)		
Evidence of obstruction		
Evidence of air passage defect		

SECTION 7: To be completed only for loss of hearing

State the duration in months of patient's entire and irrecoverable loss of hearing following the injury.

Date you first determined hearing was irrecoverably lost and the residual hearing *(dB)* uncorrected and corrected as tested by audiometer in a soundproof room. Date *(mm/dd/yyyy)*_____

Insured employee - First name	Middle name	Last name

Insured's employer's name

Audiometry:

	Left ear			Right ear		
	Uncorrected	/	Corrected	Uncorrected	/	Corrected
500 Hz		/			/	
1,000 Hz		/			/	
2,000 Hz		/			/	
3,000 Hz		/			/	

Date of the test results which allowed you to determine the hearing loss lasted consecutively for the duration indicated above. Date *(mm/dd/yyyy)* _____

Audiometry:

	Left ear			Right ear		
	Uncorrected	/	Corrected	Uncorrected	/	Corrected
500 Hz		/			/	
1,000 Hz		/			/	
2,000 Hz		/			/	
3,000 Hz		/			/	

SECTION 8: To be completed only for wheelchair access modification

Did the patient suffer a loss resulting from an accidental injury? ☐ Yes ☐ No

Date of accidental injury *(mm/dd/yyyy)* _____

Does the patient now require permanent use of a wheelchair for mobility? ☐ Yes ☐ No

Is the wheelchair requirement the direct and sole cause of the accidental injury? ☐ Yes ☐ No

Name of facility			Phone number	
Address	City		State	Zip code
Attending physician - First name	Middle name		Last name	
Sign Here	Signature of attending physician		Date *(mm/dd/yyyy)*	

MetLife

About the Total Control Account®

A convenient place to hold the proceeds from your claim while you decide what to do with the money

How the account works

The Total Control Account (TCA) is a draft account that works like a checking account:

- When your account is open, MetLife1 will send you a package which includes additional details about the TCA. We pay the full amount owed to you by placing your proceeds into the TCA and providing you a book of drafts. You can use the drafts like you would use checks.
- You can use a single draft to access the entire proceeds or several drafts for smaller amounts *(as little as $250)*. There are no limits on the number of drafts you can write. Processing time is similar to check processing.
- You also may conveniently use your TCA as a source of funds to pay your bills online or by phone.
- You earn interest on the money in your account from the date your account is open.
- We'll send you an account statement each month when there is activity in your account. If you have no activity, we'll send you a statement once every three months.
- You can name a beneficiary for your account. We'll include a beneficiary form in the package we send you when we open your account.

Interest rates and guarantees

The interest rate on your account is set weekly, and will always be the greater of the guaranteed rate stated in your TCA package, or the rate established by one of the following indices: the prior week's Money Fund Report Averages™/Government 7-Day Simple Yield, or the Bank Rate Monitor™ National Money Market Index. We calculate interest daily and compound it, so you earn interest on your interest. The interest is added to your account monthly. The interest earnings generally are taxable so you should speak with your tax advisor.

No monthly maintenance fees

There are no monthly maintenance or service fees on your TCA, no charges for making withdrawals or writing drafts, and no cost for ordering additional drafts. You may be charged for special services or an overdrawn TCA, and the current fees *(subject to change)* for those services are: draft copy $2; stop payment $10; wire transfer $10; overdrawn TCA $15; overnight delivery service $25.

Other important information

- If you do not want a TCA, you may request a check by writing "check" beneath your signature on the attached claim form.
- Your Total Control Account is backed by the financial strength of MetLife. The assets backing the funds are held in MetLife's general account and are subject to MetLife's creditors. In addition, while the funds in your account are not insured by the FDIC, they are guaranteed by your state insurance guarantee association. The coverage limits vary by state. Please contact the National Organization of Life and Health Insurance Guaranty Associations *(www.NOLHGA.com or 703-481-5206)* to learn more. FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE.
- If there is no activity on your account for a period of time *(typically three years, but this may vary by state)*, state regulations may require that we contact you at the address we have on file. If we aren't able to reach you, we may be required to close your account and transfer the funds to the state.
- We may limit or suspend your access to the funds in your account if we suspect fraud or if there was an error in opening your account.
- We use the services of The Bank of New York Mellon, 701 Market Street, Philadelphia, PA 19106, for Total Control Account recordkeeping and draft clearing.
- A TCA generally is not available if your claim is less than $5,000, you reside in a foreign country, or if the claimant is a corporation or similar entity.
- We may receive investment earnings from operating the Total Control Account. The performance results of any investments we make do not affect the interest rate we pay you.
- To learn more about TCA, please call us at 800-638-7283 *(TDD callers: 800-229-3037)* or write us at Metropolitan Life Insurance Company, Total Control Account, PO Box 6300, Scranton, PA 18505-6300.

[1] *"MetLife" means Metropolitan Life Insurance Company or the MetLife affiliate that issued the underlying policy*

Total Control Account® is a registered service mark of Metropolitan Life Insurance Company.

MetLife

Fraud Warnings

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 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 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.

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.