Georgia®
Department of Administrative Services
Customer Focused, Performance Driven

MetLife
Metropolitan Life Insurance Company
P.O. Box 14632
Lexington, KY 40512-4632
Phone: 1-877-255-5862
Fax: 1-315-792-6600

Instructions for Completing Group Life Insurance Statement of Review

- **Continued Protection (Premium Waiver During Total Disability)**
- **Total & Permanent Disability**

Employer's Statement

1. The Employer's Statement should be completed by someone who is familiar with the employee's potential eligibility for Premium Waiver, or Total Permanent Disability.
2. Complete Sections 1, 2, & 3 of the Employer's Statement and sign at the bottom of the page.

   Note: **Failure to complete all sections or sign the Employer's Statement will cause a delay in processing.**
3. Give the completed Employer's Statement and all remaining pages including this page to the employee for further processing. You may wish to retain a copy of the completed Employer's Statement for your records.
4. Contact MetLife with any questions you may have when completing this form.

   Important: Since MetLife does not maintain your Group Life records, please attach all enrollment forms, beneficiary designation, and any other forms in the life insurance file.

Employee's Statement

1. The Employee's Statement must be completed by the employee or his/her legal representative. If you are an Authorized Representative completing this form, please include a copy of the legal document(s) authorizing you to act on the Employee's behalf.
2. Complete the Employee's Statement.
3. Sign the following pages:
   a) the Employee's Statement
   b) the Authorization to Disclose Information About Me
   c) the Attending Physician Statement, Section A
4. Give the Attending Physician Statement to your treating physician for completion.
5. Contact MetLife with any questions you may have when completing this form.
6. Place your name and Social Security number in the allocated area of each page.
7. Submit the entire form to MetLife at the above address.

GROUP LIFE INSURANCE STATEMENT OF REVIEW

Please check all appropriate boxes for this submission

☐ **Continued Protection (Premium Waiver During Total Disability)**

☐ **Total & Permanent Disability**

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EMPLOYER'S STATEMENT

Section 1: Employer Information

Important: MetLife does not maintain your Group Life records, please attach all enrollment forms, beneficiary designation, and any other forms in the life insurance file.

Employer Name			
Address of Employer or Group Policyholder	City	State	Zip Code
Name of Group Policyholder if different than the Employer **State of Georgia**			
Address of Group Policyholder if different than the Employer **200 Piedmont Ave. SE, Suite 502, West Tower**	City **Atlanta**	State **GA**	Zip Code **30334**

Contact Person's Name	Phone #	Fax #	E-mail Address

Section 2: Employee Information

Name (Last, First, MI)	Social Security # - **REQUIRED**	Date of Birth (MM/DD/YY)

Address	City	State	Zip Code

Claimant's Occupation/Job Title (Attach a job description)	Date of Hire		Base Wages as of Last Date Worked	Number of hours worked per week:
		☐ Salaried	$_____ ☐Weekly ☐Monthly	

Section 3: Coverage Information

Date Last Worked?	Why did employee cease work on that date?

*An amount of insurance needs to be reported for Employee Coverage claimed.

Coverage	Employee, Spouse, or Dependent?*	Amount of Insurance	Report Number	Sub Code Number	Branch Number	Employee Life Insurance Effective Date	Date Insurance Amount Last Changed	Cancellation Date (if any)	Premium Payments Terminated?	Has Policy converted to an Individual Policy?
Supplemental/ Optional Life	☐ Employee	$ _____	**150560**	**0001**	**0001**				☐ Yes ☐ No	☐ Yes ☐ No

Does your Company Provide Retirement Benefits? ☐ Yes ☐ No If "Yes," please answer these questions:	Check Type of Benefit: ☐ Normal ☐ Disability Would the Employee Qualify? ☐ Yes ☐ No	Date on which Employee would qualify?

Employer's Authorized Representative

Name (Please Print) _____ Title _____ Phone # _____

Signature _____ Date Signed _____

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.

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.

Arkansas, District of Columbia, Louisiana, 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.

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 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 purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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: 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.

Vermont: Fraudulent insurance act. No person shall, with intent to defraud: present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.

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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GROUP LIFE INSURANCE STATEMENT OF REVIEW

- **Contact MetLife with any questions you may have when completing this form.**
- **Submit the entire form by mail to the above address for processing – retain a copy for your records.**

Important: **To avoid processing delays, please complete the form in its entirety and submit all requested Documents.**

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EMPLOYEE'S STATEMENT

Section 1: Personal Information

Name (Last, First, MI)	Social Security # - **REQUIRED**	E-Mail Address (Optional)

Address	City	State	Zip Code	Date of Birth (MM/DD/YY)	☐ Male ☐ Female

Home Phone #	Occupation	Marital Status ☐ Married ☐ Single ☐ Other

Education (Select highest level completed) ☐ GED ☐ High School ☐ Associate Degree ☐ Bachelors Degree
☐ Vocational/Other _____ ☐ Masters Degree or higher _____

Dependent Information for Group Life Insurance:

	Name	Date of Birth	SS#
Spouse			
Children			

Section 2: Disability Information

Date Last Worked	State the cause of your Disability:	On what date were you first treated by a physician related to this disability?

Name(s) of all Physicians/Providers who have treated you since the beginning of this disability:

Name of Physician/Provider	Address	Phone Number (Include Area Code)	Dates of Treatment	Reason for Visit

Have you performed any type of work (either for this employer, another employer or through self-employment) since your disability began?
☐ Yes ☐ No If "Yes," provide the following information:

Name of Employer	Address of Employer	Type of Work	Date Employment Began	Hours Worked Per Week

Are you presently able to engage in any gainful occupation? ☐ Yes ☐ No
If "Yes," please explain: _____
If "No," when do you expect to return to work? Date _____

Are you insured under any other policies issued by MetLife? ☐ Yes ☐ No
If "Yes," please provide coverage type and policy numbers: _____

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. I have read the applicable Fraud Warning(s) provided in this form.

_____ _____
Employee Signature Date Signed

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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).

Your refusal to complete and sign this form may affect your eligibility for benefits under your employer's life plan.

Name of Claimant (Please Print) _____ Social Security Number _____

Authorization to Disclose Information About Me

For purposes of determining my eligibility for continued life insurance coverage due to a disability or for the total and permanent disability benefit under the administration of my employer's life benefit plan, as the case may be, 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 life benefit 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 disability claim.

2. **I permit** MetLife to disclose to my employer in its capacity as administrator of its benefit plans any and all information about my health, medical care, employment, and disability claim.

This Authorization to Disclose Information About Me 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 at P.O. Box 14632, Lexington, KY 40512-4632, 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.

Signature of Claimant or Authorized Representative _____ Date Signed _____

ATTENDING PHYSICIAN STATEMENT

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EMPLOYEE:
Instructions for completing the claim form:
1. Complete all applicable areas of the form.
2. Sign the claim form.
3. Fax this claim form along with the Objective Findings to expedite your claim – retain originals for your records.

ATTENDING PHYSICIAN:
Objective Findings to be Included:
- Diagnostic Testing results (x-rays; lab tests; EKG's; MRI's and scans).
- Office Visit Notes (from patients date last worked to present).
- Admission or Discharge Summaries for recent hospitalizations/surgeries.

Section A

Name	Social Security # **Required**	Date of Birth
Policyholder State of Georgia	Occupation	Group Report # 150560
I hereby authorize my physician to release any information acquired in the course of my examination or treatment. **Signature of Employee** _____ Date Signed _____		

Section B

The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form. A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: ☐ Injury ☐ Illness	Is condition work-related? ☐ Yes ☐ No	Initial date of treatment	Most recent date of treatment
Did you advise the patient to cease the above noted occupation? ☐ Yes ☐ No		If Yes, Date	
Names and Phone Numbers of the other providers the patient was referred to:			
Name	Phone #	Name	Phone #
Has patient been hospitalized? ☐ Yes ☐ No	If Yes, Date Confined _____ through _____		
Name and address of facility:			

Diagnosis and Treatment

Primary ICD-9 _____ . _____ Diagnosis _____

Secondary ICD-9 _____ . _____ Diagnosis _____

Subjective Symptoms _____

Objective Findings (Include copies/results of any x-rays, lab tests', EKG's, MRI's, scans and office notes)

_____

Current and Recommended Treatment Plans _____

_____

_____

If surgery performed/anticipated, provide the following:

_____

CPT-4 _____ Procedure _____ Date _____

Medications prescribed (names, dosages)

_____ _____

_____ _____

_____ _____

Name of Employee _____ **Social Security Number** _____

Psychological Functions – Check applicable box below

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

What stress factors or problems with interpersonal skills have affected patient's ability to perform the duties of his or her job?

Is patient competent to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

Physical Capabilities

(a) Patient's ability to: (circle)

	Hours	(check)	
Sit	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Stand	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Walk	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently

(b) Patient's ability to: (circle)

Climb	Yes	No
Twist/bend/stoop	Yes	No
Reach above shoulder level	Yes	No
Operate a motor vehicle	Yes	No

(c) Patient's ability to lift/carry: (check)

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67%-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐
Over 100 lbs.	☐	☐	☐	☐

(d) Patient's ability to perform repetitively: (circle)

	Right Hand		Left Hand	
Fine finger movements	Yes	No	Yes	No
Eye/hand movements	Yes	No	Yes	No
Pushing/pulling	Yes	No	Yes	No

Dominant hand ☐ Right Hand ☐ Left Hand

(e) In your opinion, why is patient unable to perform job duties?
(f) Patient can work a total of _____ hours per day?
(g) Do you expect improvement in any area? (If so please comment and give dates/timeframes.)
(h) Has patient reached maximum medical improvement? ☐ Yes ☐ No If YES, is the condition permanent? ☐ Yes ☐ No

Cardiac: Functional Capacity (American Heart Association) Complete only if applicable.

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)
Blood pressure (latest reading) _____ / _____ as of (date) _____ / _____
Is patient in a cardiac rehabilitation program? _____

Extent of Disability	For Any Occupation	For His/Her Regular Occupation
(a) Is Patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
(b) If no, when was patient able to go to work?	Mo. _____ Day _____ Yr. _____	Mo. _____ Day _____ Yr. _____
(c) If yes, when do you think patient will be able to resume any work?		
Approximate Date:	Mo. _____ Day _____ Yr. _____	Mo. _____ Day _____ Yr. _____
Indefinite:	☐	☐
Never:	☐	☐

Rehab

Do you suggest that the patient become involved in any of the following? Please check as many as apply.
If so, was this discussed with the patient? ☐ Yes ☐ No

☐ Physical Therapy ☐ Pain Management Program ☐ Vocational Rehabilitation
☐ Occupational Therapy ☐ Work Hardening Program ☐ Psychological Counseling
☐ Cardiac Rehabilitation ☐ Job Modification ☐ Other _____

Physician

Print Name _____ Degree/Specialty _____
Street Address _____ City _____ State _____ Zip Code _____
Telephone # _____ Fax # _____ Tax ID # _____
Contact person if additional information is necessary _____
Signature _____ Date Signed _____

Please be sure to submit the Objective Findings outlined on the first page of this Attending Physician Statement (include copies/results of any x-rays, lab tests, EKG's, MRI's, scans and office notes).