Completing your LTD Claim Form For Occupational PTSD

MetLife

Complete the necessary information in Section 1

completing this form.

SECTION 1: Personal information

First name *(Must answer)*	Middle initial	Last name
Employer *(Must answer)*		ID number *(If applicable)*
Address	City	State / ZIP code
Date of birth *(mm/dd/yyyy)*	Sex ☐ M ☐ F	Social Security number *(Must answer)*

We require a street address for our records if a P.O. Box is your mailing address

Home phone number	Mobile phone *(Optional)*	Occupation
Marital status ☐ Married ☐ Single ☐ Other	Tax exemptions	Personal email

First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	Social Security number	
First name	Middle name	Last name
Date of birth *(mm/dd/yyyy)*	Social Security number	

SECTION 2: Claim information

Is your disability due to ☐ Injury/Accident? ☒ Illness? **Check Illness**

If due to injury/accident, give date, time and details. *(When, where, how)* **Leave blank**

Is this condition work related? ☒ Yes ☐ No **Check Yes**

Date of first treatment for this condition *(mm/dd/yyyy)* **Leave blank**

Enter the last date that you were able to work as a First Responder

Date last worked *(Must answer) (mm/dd/yyyy)*

Date disability began *(mm/dd/yyyy)*

Enter the date you were first unable to perform regular First Responder duties due to Occupational PTSD

Primary attending physician

Enter the name of the Qualified Diagnostician who diagnosed your Occupational PTSD

First name	Last name	
Address	City	State / ZIP code
Phone number		

Name of physicians/providers who have treated you within the past 2 years.

Leave blank

First name	Last name	Specialty
Phone number	Fax number	Dates of treatment From To
Reason for treatment		
First name	Last name	Specialty
Phone number	Fax number	Dates of treatment From To
Reason for treatment		

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Navigating life together

Cross highest education level completed.

Leave this section blank

☐ 9
☐ 18

Degrees, certificates, license/skills or training obtained

Please describe what prevents you from performing the duties of your job.

**Describe your duties as a First Responder and how your Occupational PTSD prevents you from doing them.
Attach all guidance or medical records from your psychiatrist, psychologist, or other provider(s) with a medical specialty appropriate for diagnosing PTSD who has advised you not to perform these duties or stated you should not perform them.**

Have you applied for or are you receiving income from any other sources? ☐

If yes, provide the following information.

	Applied for	Receiving	$ Amount	Frequency	From date (mm/dd/yyyy)	To date (mm/dd/yyyy)
Salary continuance/Sick leave **	☐	☐				
Short term disability ***	☐	☐				
Worker's compensation ****	☐	☐				

****If you are working while Disabled for the PPE or for another Public Entity and are receiving partial wages, disability income benefits paid to You under this Certificate will only be reduced to the extent that your wages from the PPE while unable to perform Your First Responder duties and the disability income benefit paid under this Certificate exceed 100% of Your Pre-disability Earnings.**

***** Leave blank if you paid any part of the cost of this benefit or if it is not an employer-sponsored benefit.**

****** Answer no unless the workers' compensation income is due to your Occupational PTSD.**

+ Leave blank

Please note this is a standard MetLife form that requests information and addresses repayment of certain reductions to benefit payments that do not apply to this program. Please follow these instructions when completing the form and be assured that MetLife will not reduce benefits except as stated in the Certificate.

Attach this to the LTD claim form.