MetLife

Metropolitan Life Insurance Company
Statement of Health Unit
Telephone Number: 1-800-638-6420, Prompt 1

Statement of Dependent Eligibility Beyond Limiting Age In Plan Due to Mental or Physical Handicap

Note: In order to be eligible for coverage when the Dependent reaches the age limit, he/she must have been previously enrolled for Life.

Employee's Statement	**Answer all questions.** **Omitted information will cause delays.**	**First Request:** ☐ **Yes** ☐ **No** **Prior Request Date (MM/DD/YYYY)** / /

Employee Information

Name First Middle Last (Print)	Social Security # – –	Date of Birth (MM/DD/YYYY) / /	☐ Male ☐ Female
Present Street Address: City State Zip Code	Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced	Phone (Including Area Code) ( ) –	

Dependent Information

Name First Middle Last (Print)	Social Security # – –	Date of Birth (MM/DD/YYYY) / /	Age	☐ Male ☐ Female
Present Street Address: City State Zip Code	Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced	Relationship to Employee		

Name and address of Dependent's current employer: _____

_____

_____

_____

If you are a new Employee continuing Dependent coverage from a prior carrier, indicate the following:

Life Carrier Name: _____ Policy # _____ Phone # (_____) _____ – _____

If not now employed, give date last employed: ___/___/___	Estimated income of Dependent from all sources $_____ monthly	Percentage of support of Dependent supplied by Employee _____ %	Is the Dependent permanently residing in Employee's household? ☐ Yes ☐ No If No, Explain: _____

Is Dependent listed as a Dependent in your last Federal Personal Income Tax Return? ☐ Yes ☐ No

If No, Explain: _____

_____

_____

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. Group insurance may be continued past the plan's age limit if the covered child is incapable of self-sustaining employment because of a mental or physical handicap. Proof of such handicap must be provided to MetLife within 31 days after the date the child attains the age limit. Children who exceed the age limit prior to sustaining a mental or physical handicap are not eligible for coverage, nor are children who were not insured under the MetLife Group Policy prior to attainment of the plan's age limit, regardless of handicap status.
3. I have read the applicable Fraud Warning(s) provided in this form.

► Employee Signature	Date Signed (MM/DD/YYYY) / /

Make a Copy for Your Records & FAX or MAIL Completed Forms to:
MetLife SOH Unit (Fax) 1-859-225-7909 or (Mail) PO Box 14069, Lexington, KY 40512-4069
For Inquiries, Contact 1-800-638-6420, Prompt 1 (Statement of Health Unit) or email eoi@metlife.com

Physician's/Surgeon's Statement

(Any fee for completion of this statement is to be paid by the Employee.)
Answer all questions below. Omitted information will cause delays

Patient's Name (Print) First Middle Last

Patient's Date of Birth (MM/DD/YYYY) / /

Is this Dependent presently incapable of self-sustaining employment by reason of:

Physical Handicap? ☐ Yes ☐ No

Mental Handicap? ☐ Yes ☐ No

Other (explain) ☐ Yes ☐ No

If "other," explain: _____

Date Dependent became incapable of self-sustaining employment. (MM/DD/YYYY) / /

Diagnosis of condition causing incapacity. Give as much detail as possible. Please give date and report of surgery, X-rays, electrocardiograms, or other special tests. Use separate sheet of paper if necessary.

_____

_____

_____

_____

_____

Functional Age Level:

_____

Does the patient have a job? ☐ Yes ☐ No

Do you know what the patient's job is? ☐ Yes ☐ No

Do you know what duties the patient's job requires? ☐ Yes ☐ No

Has this patient been able to do full or part-time work of any kind?

☐ No ☐ Yes, From ___/___/___ Date (MM/DD/YYYY)

Will the patient be capable of self-support?

☐ No ☐ Yes, From ___/___/___ Date (MM/DD/YYYY)

If "No," provide an explanation on a separate sheet of paper.

The patient is presently (check one) ☐ Ambulatory ☐ Bed confined ☐ House confined ☐ Hospital confined

Physician's/Surgeon's Name (Print) First Middle Last

Phone (Including Area Code) ( ) –

Physician's/Surgeon's Address: Street City State Zip Code

► Signature

Date Signed (MM/DD/YYYY) / /

Employer's Statement

To be Completed by Authorized Customer Representative.
Answer all questions. Omitted information will cause delays.

Employee's Name (Print) First Middle Last

Social Security/ID Number – –

What Dependent coverage is this form being submitted for? ☐ Life

For verification purposes, attach a statement showing that the Dependent previously had this coverage.

Dependent's effective date (MM/DD/YYYY) / /

Employer Name	Group Report Number	Sub Code	Branch

Employer Contact Name	Employer Contact Title	Employer Contact Email	Employer Contact Phone ( ) –

Street Address	City	State	Zip Code

Authorized Customer Rep. Name	Title

► Signature

Date Signed (MM/DD/YYYY) / /

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FRAUD WARNINGS

Before signing this 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, 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.

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.

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 an application for insurance 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 Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits): 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

Oregon and Vermont: Any person who knowingly presents a false statement in an application 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.

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.