Disability Claims

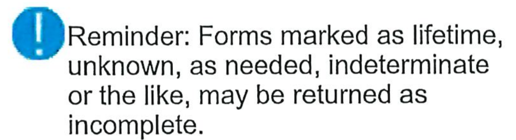
MetLife

Certification of health care provider for Employee's serious health condition Family and Medical Leave Act (FMLA)

Metropolitan Life Insurance Company

Things to know before you begin

- Please complete Section 1 before giving this form to your medical provider.
- The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefits FMLA of protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.
- Remember to include your First name, Last name and Claim number in the spaces provided on all pages of this form.



SECTION 1: Employee Information

Employee - First name	Middle name	Last name	Claim number

Employer's name ____________________

SECTION 2: Health Care Provider Instructions

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency and length of a condition, treatments, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the employee is seeking leave. Be as specific as you can; terms such as *lifetime, unknown, as needed, or indeterminate* may not be sufficient to determine FMLA coverage. Without sufficient medical facts, this form may be returned as incomplete. Please be sure to sign the form on the last page.

Which of the following best describes your patient's medical condition? ☐ Pregnancy ☐ Injury ☐ Illness

If pregnancy, please provide date *(select one):* ☐ Estimated delivery date ☐ Actual delivery date __________

What is the approximate date the condition commenced? __________

What is the estimated date the condition may conclude? __________

Will the patient need treatment visits at least twice per year due to this condition? ☐ Yes ☐ No

Was medication prescribed that may not be obtained over the counter? ☐ Yes ☐ No

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? If yes, please provide admission and discharge dates below. ☐ Yes ☐ No

First name | Middle initial | Last name | Claim number

Date admitted *(mm/dd/yyyy)* | Date discharged *(mm/dd/yyyy)*

Dates you treated the patient for this condition:
First visit *(mm/dd/yyyy)* | Last visit *(mm/dd/yyyy)* | Next visit *(mm/dd/yyyy)*

Are there any other treating physicians or consultants involved in your patient's care? ☐ Yes ☐ No

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work *(i.e., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).*

Note to California physicians: You may not disclose your patient's diagnosis without your patient's consent.

Job restriction details:

Were you provided with a job description for your patient, or did you discuss the essential functions of their job? ☐ Yes ☐ No

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If so, identify the job functions the employee is unable to perform:

SECTION 3: Amount of Leave Needed

Continuous absence details: Will your patient need to be absent from work for a single continuous period of time due to their own serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

☐ Single continuous absence period | Start date *(mm/dd/yyyy)* | End date *(mm/dd/yyyy)*

Intermittent absence details: Will your patient need an intermittent absence and/or reduced work schedule due to their own serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent absence outlined below.

☐ Intermittent absence/Reduced work schedule | Start date *(mm/dd/yyyy)* | End date *(mm/dd/yyyy)*

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have.

Example:
FREQUENCY of episode 02 times per: ☐ week, or ☒ month, or ☐ year
LENGTH of episode: ___ minute(s) 01 hour(s) ___ full day(s)

FREQUENCY of episode ___ **times per:** ☐ week, or ☐ month, or ☐ year

LENGTH of episode: ___ minute(s) ___ hour(s) ___ full day(s)

First name	Middle initial	Last name	Claim number

SECTION 4: Health Care Provider Information

Physician - First name	Middle name	Last name

Physician area of specialty *(i.e., General Practitioner, Oncologist, Obstetrician)*

Office phone number	Office fax number

Office address	Suite

City	State ▼	ZIP code

Please Read:

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. *Genetic Information* as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient must be absent from work or have a modified work schedule due to this condition.

Sign Here	Signature of health care provider	Date *(mm/dd/yyyy)*

SECTION 5: How to Submit this Form

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-844-837-8086

Authorization to Disclose Information About Me

Metropolitan Life Insurance Company

Things to Know Before You Begin

- Section 2 requires your signature.
- Return this form as soon as possible to expedite processing of your claim as described in Section 3 and keep a copy for your records.
- If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Claimant's behalf and include the claim number at the top of each page

Your refusal to complete and sign this form may affect your eligibility for benefits.

HIPAA: 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)*.

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 *(GINA)* prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

SECTION 1: Claimant Information

First Name	Middle Name	Last Name

Absence Claim Number	STD Claim Number	ID Number *(if applicable)*

SECTION 2: Authorization & Signature

I understand that my employer has requested that Metropolitan Life Insurance Company *("MetLife")* integrate the claim services for disability benefits and request for leave under the Family and Medical Leave Act *(FMLA)*, state leave laws, and/or my company's leave of absence policy or request for reasonable accommodation under the Americans with Disabilities Act (ADA) *("Leave Request")*. For purposes of determining my eligibility for disability benefits and/or my Leave Request, the administration of my employer's disability benefit plan *(which may include assisting me in returning to work, or applying for Social Security Disability Insurance benefits)*, and the administration of other benefit plans in which I participate that may be affected by my eligibility for disability benefits, including but not limited to any workers compensation, employee assistance or disease management program, 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/care provider, hospital, clinic, other medical related facility or service, pharmacy benefit administrator, insurer, employer, government agency, group policyholder, contract holder or benefit plan administrator to disclose to MetLife, 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 my claim for disability benefits and/or my Leave Request.

2. **I permit:** MetLife to disclose to my employer or its agents acting in the capacity of administrator of its benefit plans or programs, including but not limited to, Workers' Compensation, employee assistance, or disease management programs, and to my employer regarding my Leave Request, any and all information about my health, medical care, employment, and claim for disability benefits or Leave Request. I also permit MetLife to contact any health care provider who has submitted a medical certification to MetLife in connection with my Leave Request in order to authenticate, clarify, or obtain any information missing from the certification.

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, diagnosis 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 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 Disability at PO Box 14590, Lexington KY 40512-4590, 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 and/or my Leave Request, 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.

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

SECTION 3: How to Submit This Form

Mail:

MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:

1-800-230-9531