

State Specific Fraud Warnings – Group Product Claim Forms

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 on 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.



INSURED ELECTRONIC CLAIM PAYMENT AUTHORIZATION FORM

Insured's Name (Please Print the Insured's Name as listed on the policy)

Last Four - Social Security

Insured's Date of Birth

Group / Policy Number

I hereby authorize Metropolitan Life Insurance Company (MetLife) to initiate electronic credit entries (payments) to the insured/policyholder's checking account indicated below, and in the financial institution (Bank) named below. This authority pertains only to claim payments due from MetLife in accordance with the insured/policyholder's Long-Term Care Insurance Coverage.

I acknowledge that with the origination of the Automated Clearing House (ACH) transactions, this checking account must comply with all the provisions of U.S. law. Please allow approximately 30 days to add or update the ACH request due to timing of the receipt of this form.

Please attach a check copy below, the insured/policyholder's name needs to be printed by the banking / financial institution on the check, and starter Checks are not accepted; If we are unable to pay through ACH system, we will then pay the benefits through paper checks until we receive the correct information.

ATTACH VOIDED CHECK HERE

Name (Insured) Name Address City, State, Zip Code	DATE _____
PAY TO THE ORDER OF _____	\$ ***VOID***
_____	DOLLARS
Name of Financial Institution	
123456789	0123456789012345 001

Provider Section: Please list each approved provider you are requesting we process the ACH claims payments for.

I understand the Long-Term Care Insurance Plans/Policies are reimbursement plans that will reimburse up to the plan/policy's limits. MetLife reserves the right to collect any payment made in excess of the plan/policy's limits. By signing this form, you acknowledge you will promptly refund any and all claim overpayments made, regardless if MetLife has paid by check or through the Automated Clearing House (ACH) system.

MetLife reserves the right to discontinue or stop the ACH payments at any time. Unless for reasons noted above, this authority will remain in full force and effect until MetLife has received written notification to change or terminate the request. Please allow approximately 30 days to add or update or stop the ACH request due to timing of the receipt of this form.

If you reside in New York, the following statement applies to you.

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.

If you reside in a state other than New York or are covered by a policy issued for delivery in another state, refer to the Fraud Warning Statements on the following pages for the statement that applies to you.

I certify that the information furnished in support of this claim is true and correct.

Signature of the Insured, Spouse, Financial Power of Attorney

Date

Signer (Please print your name)

Relationship

Telephone Number

Please send completed form by: Mail: P.O. Box 14407, Lexington, KY 40512

Fax: 866-722-1180 **Or Email:** longtermcareclaims@metlife.com