MetLife
Attn: Expatriate Benefits
600 King Street
Wilmington DE, 19801 USA
Toll Free (Within U.S.): 1-800-451-1847
Direct: +1-302-661-8674
Fax: +1-302-427-0817
Email: wilmclaims.metlifeexpat@alico.com
www.metlifeexpat.com

INTERNATIONAL CLAIM FORM

To be used by employees who reside outside the United States for services rendered outside the United States

Medical, Dental and Vision

Please mail or fax this completed form with itemized bills and receipts to the address or fax number listed above. Please tape small receipts on 8.5 X 11 inch or ISO A4 paper. Please do not staple receipts to claim form. If already enrolled with electronic fund transfer (EFT), we will automatically send payment by wire transfer if criteria are met, unless noted otherwise below. *To enroll for ETF, please download a Wire Transfer Request Form from our website at www.metlifeexpat.com

PLEASE PRINT ALL INFORMATION CLEARLY

Part A

Employee's Name: Employer Information:

First | Middle | Last | Employer Name | Group Policy Number

Mailing Address | Email

City | State | Postal Code | Country | Birth Date

Is this a permanent change of address? ☐ Yes ☐ No Employee status ☐ Active ☐ Retired ☐ Disabled ☐ Deceased

Part B

Patient's Name:

First | Middle | Last | Birth date

Patient's Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Other

Does your family have any other form of medical or dental coverage? If so, please provide details so that we may coordinate coverage. ☐ Yes ☐ No Details

Part C

Diagnosis or Chief Complaint

Is condition due to an injury arising out of patient's employment? ☐ Yes ☐ No

Part D

Payment to Employee: Please indicate where the payment should be sent.

☐ Check (payment to address as listed above)

☐ Wire Transfer (*if not already enrolled, please see abov e) Currency Preference

(If currency is not specified, payment will be made in U.S. Dollars)

AUTHORIZATION TO PAY PROVIDER (Contingent upon provider accepting assignment)

☐ Make payment directly to provider (please sign below)

Employee's Signature _____ Date _____

Part E

AUTHORIZATION TO RELEASE OR OBTAIN INFORMATION

I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator, and will be used for the purpose of claims administration and evaluation, utilization review and financial audit. This authorization shall remain valid and effective from the date of signing until revoked in writing or for the term of coverage for the policy identified above, provided such information shall be retained by the Administrator, if required by law. This authorization includes any transfer of medical information from outside the United States, including the European Economic Area, into the United States in order to process claims and service my insurance benefits.

I hereby certify the information I have provided on this form is correct to the best of my knowledge. I understand I may request and shall be furnished a copy of this authorization. I understand that a photocopy of this authorization is as valid as the original.

Date _____ Patient's Signature (Parent or guardian, if Minor Child) _____ Employee Signature _____

ATTENDING PHYSICIAN'S STATEMENT

If a full itemized bill is not available, have your physician complete this form and attach a receipt.

PART A

Patient's Name:	Date of Birth:
Employee's name if patient is a dependant:	

PART B

Diagnosis and Concurrent Conditions:	Accident Case? ☐ Yes ☐ No
(If accident case, please provide description)	
Is condition due to injury arising out of patient's employment? ☐ Yes ☐ No	
Is condition due to pregnancy? ☐ Yes ☐ No If "Yes", what was the approximate date of LMP.	

REPORT OF SERVICES (Or attach itemized bill. If previous form submitted to this admission, you need only show dates and services since last report).

Date of Service	Place of Service**	Description of Surgical or Medical Services Rendered (if hospital confinement, name hospital)	Procedure Code - if used (if Code other that CPT-4 is used, give name)	Charges
			Total Charges:	
			Amount Paid:	
			Balance Due:	

** ICD-9-CM - Int'l Classification of Diseases, 9th Rev. Clinical Modification

Place of Services (Use number Code)

1. Doctor Office	4. Outpatient Hospital	7. Surgical Center
2.Patient's Home	5. Nursing Home	8. Alcohol-Chemical Rehabilitation Center
3. Inpatient Hospital	6. Home Health Care	9. Other Briefly Described

I HEREBY CERTIFY THAT THE SERVICES LISTED HAVE BEEN PERFORMED AND THAT THE FEES CHARGED DO NOT EXCEED THE FEES CHARGED TO PRIVATE AND NON-INSURED PATIENTS.

Physician's Name (Print)	Physician's Signature	Degree	Telephone No.	Date

Street Address	City or Town	State or Province	Zip/Postal Code

FOR U.S. PHYSICIANS ONLY

Physician's Taxpayer (I.R.S.) ID Number:	Do you Accept Assignment? ☐ Yes ☐ No

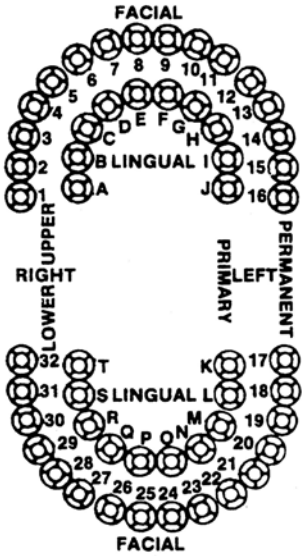
PART C - COMPLETED BY DENTIST

Dentist Name:			Is Treatment Result of Occupational Illness or Injury?	No	Yes	If YES, Enter Brief Description and Dates
Mailing Address:			Is Treatment Result of Auto Accident? Other Accident?			
City, State, Zip:			Are any Services covered by another Plan?			
Dentist Soc. Sec. ORT. I.N. Dentist License No Dentist Phone No			If Prosthesis, is this Initial Placement?			If No, Reason for Replacement Date of Prior Replacement _____
First Visit Date Current Series _____ Place of Treatment ☐ Office ☐ Hospital ☐ Home ☐ Other	Radiographs or Models Enclosed? ☐ Yes ☐ No	If Yes, how many?	Is the treatment for Orthodontics?			If Services already Commenced, enter Date Appliances Placed _____ Mos. Treatment Remaining _____

DENTISTS
Pre-Treatment Estimate
Statement of Actual Services

Examination and Treatment Plan - List in Order Tooth No. 1 through Tooth No. 32
Use Charting System Shown

* Indicate Missing Teeth With an "X"



Remarks for Unusual Services

Tooth # or Letter	Surfaces	Description of Services (Including X-Rays, Prophylaxis, Materials used , etc.	Date Services Performed Mo.	Da.	Yr.	ADA Procedure Number	Fee	For Carrier Use Only

I Hereby Certify that The Procedures as indicated by Date Have Been Completed

Total Fee Actually Charged

SIGNED DENTIST DATE

CLAIM NO.

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.

CLAIM FILING INSTRUCTIONS

To file a claim, please follow the instructions listed below.

Part A: Employee Information: This section must be answered fully and clearly to establish positive identification of your eligibility. This enables us to have accurate and current mailing information for the proper mailing of your benefit check or information.

Part B: Answer this portion in detail if the claim is for a dependant. Please respond to the last inquiry in this section, if applicable, for both employee and dependant claims.

Part C: Please include a reason (chief complaint) for the treatment or the diagnosis provided by the physician in this section if confidentiality laws prohibit the provider from entering a diagnosis on the bill or if that bill is written in a language other than English.

Part D: Complete this section to indicate your desire for a check or wire transfer of funds. If you do not indicate a preference, and a wire transfer form has been completed, reimbursement will be sent based on the completed form. If a wire form has not been completed and you have not indicated a preference for reimbursement, a check will automatically be sent.

If you prefer a wire transfer of funds and have not already submitted the necessary form, please visit our web site at http://www.metlifeexpat.com to obtain the Wire Transfer Form.

If you prefer payment to be made directly to the provider (contingent upon provider accepting assignment), please sign where indicated.

Part E: This section must be signed by the patient. (If the patient is a minor child, the employee should sign the form.). This is your certification that the information is true and correct to the best of your knowledge.

ATTENDING PHYSICIAN'S STATEMENTS
(Medical and Dental)

Your claim form contains a physician's statement for your convenience in filing your claim. Your doctor does not have to complete this statement if you have itemized bills or receipts of payment from the doctor. To be considered valid, your receipts must contain the following:

1. Name of the patient
2. Date of each service
3. Service performed
4. Amount charged for each service
5. The signature of the Provider or the Provider's representative
6. The Provider's name and address
7. The diagnosis (if confidentiality laws does not allow the provider to enter the diagnosis, enter the chief compliant on Part C of the claim form) symptoms or chief compliant on Part C of the claim form)
8. Drug bills must include the name of the medicine

SUBMITTING A CLAIM

Please mail, fax, or email a signed, completed claim form with itemized bills and receipts to:

MetLife
Attn: Expatriate Benefits
600 King Street
Wilmington, Delaware 19801 U.S.A.
Fax: +1 302-427-0817
Tel: +1 302-661-8674
wilmclaims.metlifeexpat@alico.com