MetLife
Attn: Worldwide 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.metlifeworldwide.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.metlifeworldwide.com

PLEASE PRINT ALL INFORMATION CLEARLY

Part A

Employee's Name: **Employer Information:**

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

Mailing Address | E-mail

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: **Patient's Gender:** **Relationship to Employee:**

First | Middle | Last | Birth Date

☐ Male ☐ Female ☐ Self ☐ Child ☐ Spouse ☐ 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 or accident 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 above)

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, OBTAIN AND PROCESS INFORMATION

I authorize any personal information, including sensitive information, relating to this claim to be disclosed to and acquired by DelAm and its affiliates and agents. Such information will be used for the purpose of processing, administering, evaluating and adjudicating claims, utilization review, financial audit and to service and provide insurance benefits. This authorization includes any transfer of personal information, including sensitive information, from outside the United States, including the European Economic Area, into the United States or other jurisdictions for the purposes described above. DelAm will take appropriate technical and organizational measures to protect this personal information. If applicable, I understand I may access, rectify or delete my personal information by sending a written communication to wilmclaims.metlifeexpat@alico.com. This authorization shall remain valid and effective from the date of signing until revoked by sending a written email communication to the address listed above or until the policy identified above expires, provided such information shall be retained if required by law.

To the best of my knowledge and belief, the information I provided in this claim form is true, complete, and correct. Any person who knowingly and with intent to defraud any insurance company or other person files a claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a crime, and may be subject to civil and criminal penalties.

New York: 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.

Date	(Parent's or Guardian's if Minor Child) Patient's Signature	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
2. Patient's Home
3. Inpatient Hospital
4. Outpatient Hospital
5. Nursing Home
6. Home Health Care
7. Surgical Center
8. Alcohol-Chemical Rehabilitation Center
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

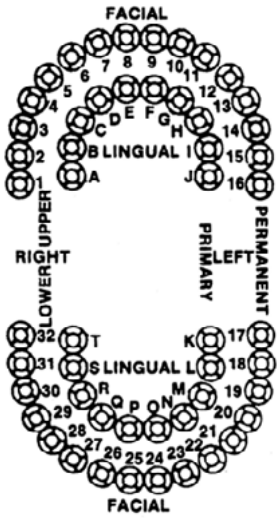
Part C - Completed by Dentist

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

State Specific Fraud Warnings – Group Product Claim Forms

FRAUD WARNINGS

Updated: January 17, 2017

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 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.