Disability Claim Reimbursement Agreement

MetLife®

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

Indicate type of claim

- ☐ ACCIDENT & SICKNESS (A&S)/SHORT TERM DISABILITY(STD)/SALARY CONTINUANCE
- ☐ LONG TERM DISABILITY (LTD)

Instructions for completing the claim form:

1. Complete all applicable areas of the claim form.
2. If you are the Authorized Representative, include a copy of the legal document(s) authorizing you to act on the Employee/Claimant's behalf.
3. Sign the claim form.
4. Fax this form to expedite your claim - retain original for your records.

Name (Last, First, Middle Initial) _____ Social Security # _____ Report # _____ Claim # _____

Agreement To Reimburse Overpayment Of Short Term Disability Benefits

I agree to reimburse Metropolitan Life Insurance Company (MetLife) and/or my employer's plan for any overpayments of disability income benefits I receive under my employer's plan. I agree that, among other things, an overpayment will arise to the extent I receive benefits from my employer's plan that are later determined to be payable to me under (1) a Workers' Compensation Law; (2) an Occupational Disease law; and/or (3) another similar law. When an overpayment arises, I agree to reimburse MetLife and/or my employer's plan for the overpayment from the proceeds I receive under such a law. If necessary, I also permit my employer to deduct the overpayment from my salary or any other benefits that may become due me, (and if appropriate, to reimburse MetLife) to the extent permissible by law.

Agreement To Reimburse Overpayment Of Long Term Disability Benefits

I, _____ acknowledge that, if my disability claim is or has been approved, under my Long Term Disability coverage, Metropolitan Life Insurance Company (MetLife) is authorized to reduce the benefits otherwise payable to me by certain amounts paid or payable to me under disability or retirement provisions of the Social Security Act (including any payments for my eligible dependents), under a Workers' Compensation or any Occupational Disease Act or Law, and under any State Compulsory Disability Benefit Law, or any other act or law of like intent.

I understand that, if my disability claim is or has been approved, MetLife is willing to make advance monthly disability payments to me, which because of amounts paid or payable under the laws described above may be in excess of the benefits actually due to me. However, I also understand and accept that MetLife will make these payments, only if I make certain statements which I represent and warrant to be true and only if I agree as follows:

1. I have not received and am not receiving any payments under the laws described above, whether in the form of benefit payment or a compromise settlement.
2. If I have not already applied for Social Security benefits, then I agree to do so as specified in my Plan of Benefits after I have received my first monthly benefit check from MetLife. As proof of this, I agree to send to MetLife a copy of the Receipt of Claim Form given to me by the Social Security Administration at the time of my application.
3. I agree to file for Reconsideration or Appeal to Social Security if Social Security denies my claim for benefits as specified in my Plan of Benefits.
4. As specified in my Plan of Benefits, when I, my spouse or my dependents receive any disability or retirement payments under the laws described above resulting from my disability, I agree to notify MetLife immediately by sending a copy of the award, notification or check to MetLife.
5. After MetLife has recalculated my monthly benefit payment and has determined the amount of the overpayment, as specified in my Plan of Benefits, I agree to repay to MetLife any and all such amounts which MetLife or employer has advanced to me in reliance upon this Agreement.
6. If for any reason MetLife or employer is not repaid, then I understand that MetLife may reduce my monthly benefit below the minimum monthly benefit amount as stated in my Plan of Benefits, until the overpayment is reimbursed in full.
7. I agree to repay MetLife in a single lump sum any overpayment on my Long Term Disability claim due to integration of retroactive Social Security Benefits.

I understand that when MetLife issues an advance, it is relying on my statements and agreements herein. My acceptance of an advance, along with my signature below, is my acceptance of terms of this Agreement.

Witness Signature _____ Date _____ Claimant's Signature _____ Date _____