



Guiding you through the insurance claims process.

Critical Illness Insurance Claim Process

Submitting a Critical Illness Insurance claim doesn't have to be challenging. Below, you'll find the information you need to make the process go smoothly, so that you can receive payments quickly and focus on your recovery.

Complete a Critical Illness Insurance claim form:

- Visit mybenefits.metlife.com to access and submit your claim form electronically. You may also call MetLife at 866-626-3705 (Monday – Friday, 8 am – 8 pm EST) to request claim forms to be sent via mail.
- 2. Be sure to complete all necessary sections outlined in the form, which includes completing Section 7 on the Physician's Attachment.
- Your physician must complete the remainder of the Physician's Attachment (all of Section 8) and return the signed and completed form. For additional information on what is needed to process a claim, please review the list of documents on the Claim Form and the details within your Certificate.
- MetLife may also request additional information to process your claim. We will request this information from your providers directly. In many instances, your physician may require a special authorization before releasing your medical information. If applicable, please send this document as quickly as possible so we can make a claim determination.
- Please include supporting documents from the provider related to the Critical Illness for which a claim is being made. The supporting documents must include: 1) verified diagnosis; 2) pathology reports, surgical notes, lab results, or clinical records that support the diagnosis of the covered condition and 3) the date(s) of verified diagnosis.

For questions, please call a MetLife Customer Service Representative at 866-626-3705.

Critical Illness Insurance

Help get financial support when you or a loved one becomes seriously ill.

Submitting a Critical Illness Insurance claim:

Once claim forms have been completed and accompanying documentation (physician statement, medical information, etc.) have been obtained, you may submit as follows:

- Submit electronically through MyBenefits E-mail to ahmetlifeclaims@metlife.com (mybenefits.metlife.com) or the MetLife Mobile App
- - · Fax or mail directly (information can be found on the claim form)

MyBenefits: quick and easy online claim submission

MyBenefits is the web portal for MetLife group participants. Once registered, you can log in to:

- · Submit a claim
- See claim status, history, and payments
- · Set up direct deposit of benefits
- · Read messages from MetLife
- · Download accident and health forms
- Sign up for electronic communications by providing your email address

You can register at www.mybenefits.metlife.com.

What happens after my claim is submitted?

A MetLife Claims Specialist will review your information and request any additional medical information (if necessary). An acknowledgement letter is sent from MetLife when the claim is successfully submitted.

Visit MyBenefits or the MetLife Mobile App frequently to check claim status, letters and benefit payments.

Approval process and payment process:

There are two available payment methods, which are a physical check or direct deposit. Upon claim approval, an Explanation of Benefits (EOB) explains the claim that was processed, and payment provided. The EOB is attached to the check or available to be viewed on MyBenefits if payment is made via direct deposit. Payments to the claimant will be received within 7 – 10 business days after the claim is approved.¹

Important information — Before submitting your claim, be sure to read your MetLife certificate carefully to see what you are eligible for. The certificate issued by MetLife contains detailed information on the covered services and benefits for which you are eligible to submit a claim. Therefore, it is important that you read your certificate carefully before submitting a claim.

Your MetLife certificate can be found on mybenefits.metlife.com under the Certificate Detail tah

METLIFE'S CRITICAL ILLNESS INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability may vary by state. In most plans, there is a pre-existing condition exclusion. After a covered condition occurs, there is a benefit suspension period during which most plans do not pay recurrence benefits, except in the case of insureds covered under a New York certificate. MetLife offers CII on both an Attained Age and an Issue Age basis. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. MetLife's Issue Age CII is guaranteed renewable, and may be subject to benefit reductions that begin at age 65. Premium rates for MetLife's Issue Age CII are based on age at the time of the initial coverage effective date and will not increase due to age; premium rates for increases in coverage, including the addition of dependents' coverage, if applicable, will be based on the covered person's age at the time of the initial coverage effective date. Rates are subject to change for MetLife's Issue Age CII on a class-wide basis. A more detailed description of the benefits, limitations, and exclusions applicable to both Attained Age and Issue Age CII can be found in the applicable Disclosure Statement or Outline of Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI or GPNP14-CI, or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York, MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses. MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.



^{1.} Applies only to "clean" claims. A clean claim is a claim submitted with all the required information necessary to process the claim — no missing information requiring additional follow-up with the subscriber. It generally takes 10 business days to process "clean" claims.