Group Income Protection policy claim

PO Box 1411
Sunderland
SR5 9RB

www.metlife.co.uk

To be completed by the claimant (the employee of the policyholder)

Please note that the issue of this claim form by MetLife does not constitute an admission of any liability by MetLife in respect of the claim under your employer's policy. It is important that you provide as much information as possible to enable the assessment of the claim to proceed as quickly as possible. You are under a duty to provide true, accurate and complete information in this claim form and when providing information to MetLife in order for us to assess the claim. If untrue, misleading or inaccurate information is given by you deliberately, or recklessly, or carelessly, it may result in the claim being rejected. Please return the completed form to your employer.

Please also ensure that you sign both copies of the declaration and consent found on pages 9 to 12. One declaration should be returned to MetLife and the other sent to your GP with the request for medical records form.

Section 1 - Your details

Please complete in block capitals

Employer's name

Your name including title e.g. Mr, Mrs etc

National Insurance number (This can be found on your wage slip)

Date of birth D D M M Y Y Y Y

Contact address

City Country Postcode

Telephone number

Home Work Mobile

Email address

What is your:

Height (feet or metres) | Weight (stones or kilograms)

Are you predominantly ☐ right handed ☐ left handed

Please provide the following information (if applicable)

Spouse's or civil partner's name	Date of birth
	D D M M Y Y Y Y

Dependant childrens' names

	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

Any other dependant's name

	D D M M Y Y Y Y
	D D M M Y Y Y Y

Section 2 - Your work

1. What was your job role immediately prior to your absence from work due to illness or injury?

2. Please enclose a job description. If not available, please describe your normal duties in detail.

3. How long have you been in your current role?

4. Please detail the requirements of your job?

% of daily work	<10%	10% - 30%	30% - 50%	50%
Sitting				
Standing				
Walking				
Lifting				
Climbing				
Other (please specify)				

If your job involves lifting please confirm the amounts

% of daily work	<10Kgs	10 - 20Kgs	20 - 30Kgs	30 - 40 Kgs	40+ Kgs
Rarely					
Moderately					
Frequently					
Constantly					

a. Please advise whether any specific licenses are required to enable you to carry out your job (excluding a standard driving license).

b. Are any special skills or tools needed?

c. If travel is required, please state what type of transport you would normally take and if you drive what is your average mileage traveled per annum?

5. In what environmental conditions would you normally expect to work? (e.g. office, factory, any extremes of heat or cold, outdoors etc).

6. How many hours are you contracted to work during the week?

a. Are you involved in any shift work, weekend work or required to work additional hours on a regular basis? If 'Yes', please give details.

7. Do you supervise any other staff? If yes, how many? ☐ Yes ☐ No

8. Please list below details of any qualifications and courses you have completed for your role.

9. List below your job history, including dates and positions held.

Position		From D D M M	To D D M M
Position		From D D M M	To D D M M
Position		From D D M M	To D D M M
Position		From D D M M	To D D M M
Position		From D D M M	To D D M M

10. When were you last in contact with your employer?

D D M M Y Y Y Y

a. Have you discussed options for returning to work with your employer? ☐ Yes ☐ No

b. Do you know whether your position is still available for you to return to? ☐ Yes ☐ No

c. Do you know whether there is any alternative work available for you, and / or would you be able to return to a less demanding role? If 'Yes', give details. ☐ Yes ☐ No

11. Are you planning or considering returning to any form of work either on a part or full time basis? If 'Yes' please provide details. ☐ Yes ☐ No

Section 3 - Your income

1. Are you receiving any types of state benefits? ☐ Yes ☐ No
If so, which benefits are you receiving and from when did you start receiving these:

Benefit	Start Date
	D D M M
	D D M M
	D D M M
	D D M M

2. If you are not receiving state benefits (that you have detailed above) have you been assessed for this? ☐ Yes ☐ No

If you have not been assessed is an assessment planned? ☐ Yes ☐ No

3. Are you receiving income from any other sources? ☐ Yes ☐ No
Please state the relevant insurances covering illness or injury

Insurer	Cover	Income	Start Date
			D D M M
			D D M M

Pensions - Source		Income	Start Date
			D D M M
			D D M M

Other - Source		Income	Start Date
			D D M M
			D D M M

Section 4 - Your health

1. What is the illness or injury you are currently suffering from?

   a. When did symptoms first occur? What were these symptoms? ☐ Yes ☐ No

   D D M M Y Y Y Y

   b. How do they impact your ability to work?

   c. From what date did this prevent you from following your normal occupation?

   D D M M Y Y Y Y

   d. Have you ever suffered from this condition in the past? If 'Yes', give details and dates. ☐ Yes ☐ No

   e. What do you believe to be the cause of your illness or injury?

2. How often are you affected by your illness or injury and how long does this last?

3. Does the severity of your illness or injury vary? If 'Yes', give details. ☐ Yes ☐ No

4. What medication are you currently taking? Please include dosage.

5. What other treatment are you receiving? e.g. physiotherapy, counselling or alternative medicine.

6. Are you using any physical aids e.g. walking sticks or collars? ☐ Yes ☐ No
   Are they beneficial? ☐ Yes ☐ No

7. a. Is your current treatment providing any relief of symptoms? ☐ Yes ☐ No
   b. Are there any side effects from this treatment? ☐ Yes ☐ No
   If yes, please state what:

8. Please provide the name and address of your usual GP
   Name

   Address

   City Country Postcode

9. Have you been referred to any specialists or consultants? ☐ Yes ☐ No
   If yes, please state name, address of specialist, type of specialist and give the date of your last and of any future consultation.

   Name

   Address

   City Country Postcode

   Type of specialist

   Date of last appointment
   D D M M Y Y Y Y

   Future appointments
   D D M M Y Y Y Y D D M M Y Y Y Y D D M M Y Y Y Y

   Name

   Address

   City Country Postcode

Type of specialist

Date of last appointment

D D M M Y Y Y Y

Future appointments

D D M M Y Y Y Y D D M M Y Y Y Y D D M M Y Y Y Y

Name

Address

City Country Postcode

Type of specialist

Date of last appointment

D D M M Y Y Y Y

Future appointments

D D M M Y Y Y Y D D M M Y Y Y Y D D M M Y Y Y Y

10. Have you been referred to Occupational Health by your employer? If yes, please provide details.

Section 5 - Impact on you

1. For how long are you able to undertake the following activities (in hours per day):

Walking		Sitting		Standing	
Lifting				(please advise what weight you are able to lift)	
Climbing i.e. ladders/stairs		Bending		Driving	

2. What are your current difficulties in terms of your activities of daily living?
(e.g. shopping, gardening, cleaning, washing, bathing independently, cooking, etc).

3. What are your hobbies and interests?

Are you able to continue with these? If not, please specify why not? ☐ Yes ☐ No

Have you developed any new interests since your illness or injury began? ☐ Yes ☐ No
If yes, please provide further details of this interest(s) below:

4. Have you discussed returning to work with your GP? If 'Yes', please give details. ☐ Yes ☐ No

If no, would you like us to arrange a consultation with someone you could discuss this with? ☐ Yes ☐ No

Section 6 - Declaration and consent - this declaration should be returned to MetLife

Claimant's personal details

Name

Address

City Country Postcode

Telephone number

Email address

Access to medical reports

It may be necessary for us to ask any doctor who has attended you to provide us with a medical report, but before we can do this, we need your consent. Before signing the declaration below, you should know that you have certain rights under the Access to Medical Reports Act 1988 and/or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. You do not have to give your consent, but if you do not, we may be unable to proceed with processing the claim. You can say whether you wish to see the report before it is sent to us.

We will then tell you if we request a report from your doctor. We will also inform your doctor that you wish to see the report before it is sent to us. You will then have 21 days to contact your doctor to arrange to see this report. If you choose not to see the report before it is sent, you can ask your doctor for a copy within 6 months of it being supplied to us. If you consider any part of the report to be misleading, you can ask your doctor to amend it. If your doctor refuses, you may add your own written comments. Your doctor does not have to let you see any part of the report if, in their opinion, you or others would be harmed by it, or if the report contains information about another person, unless that person consents to you seeing the report. You will be informed if any part of the report is affected in this way. If the whole report is affected, your doctor will not send it to us unless you agree.

Please note that if you do wish to see any report before it is sent to us then this may cause the processing of the claim to take longer than would otherwise be the case.

Data Protection

MetLife is the data controller in respect of any personal data you provide to us. The ways in which MetLife may collect, share or process your personal data are explained in MetLife's Privacy Notice. MetLife's Privacy Notice also explains your rights regarding your personal data. A copy of MetLife's Privacy Notice is available on our website, www.metlife.co.uk.

Should you have any questions or concerns, please contact the MetLife Data Protection Officer at DataProtectionUK@MetLife.com.

Declaration and consent

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By signing below, I confirm I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 and/or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991. I consent to MetLife applying to my treating doctors or medical practitioners to obtain medical reports and my medical notes and records.

☐ I do* ☐ I do not* want to see any report before it is sent to MetLife. (*Please tick as appropriate)

I consent to MetLife requesting information from any doctor or medical practitioner who has treated me in respect of any medical condition affecting my physical or mental health. I authorise my treating doctor and my treating medical practitioner to release copies of my medical notes and records to MetLife and I authorise my doctor or medical practitioner to provide a report on production by MetLife of a copy of this consent. I confirm that a copy of this signed consent shall have the same validity as the original.

I declare that the information disclosed by me in this form, or in support of the claim, is true, accurate and complete. I understand that if I have provided untrue, misleading or inaccurate information deliberately or recklessly or carelessly, it may result in the claim being rejected.

Name of claimant

Date

D	D	M	M	Y	Y	Y	Y

Signature

Declaration and consent
This declaration should be sent to your GP with the request for your medical records

Claimant's personal details

Name

Address

City | Country | Postcode

Telephone number

Email address

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Name of claimant

Date

D	D	M	M	Y	Y	Y	Y

Signature

metlife.co.uk