

# Employee claim form

MetLife  
PO Box 1411  
Sunderland  
SR5 9RB  
0800 917 1222  
[www.metlife.co.uk](http://www.metlife.co.uk)

**To be completed by the employee when a claim is being submitted by the employer**

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 you provide misleading information it may result in the claim being rejected. Please return the completed form to your employer. Please note that we may need to obtain further information from your employer regarding the claim.

**Please also ensure that you print, fill in and sign the declaration and consent at section 6 of this claim form by hand.**

## Section 1 - Your details

Please complete in block capitals

Employer's name

Your name including title e.g. Mr, Ms

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## Section 2 - Your work

1. What was your job role immediately prior to your absence from work due to illness or injury?
2. 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%
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Sitting

Standing

Walking

Lifting

Climbing

Other (please specify)

If your job involves lifting please confirm the amounts in kilograms (kg)

% of daily work	<10kgs	10 - 20kgs	20 - 30kgs	30 - 40 kgs	40+ kgs
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Rarely

Moderately

Frequently

Constantly

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

b. Are any special skills or tools needed?

c. If you need to travel as part of your role, please tell us what transport you would normally use, and your average mileage per year (please don't include your commute to work).

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

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.

Yes

No

7. Do you supervise any other staff? If yes, how many?

Yes

No

8. 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. Is your position still available for you to return to?

Yes

No

Don't know

c. Is there 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

Don't know

9. 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 income from any other sources?  
If yes, please state the sources of income being received as a result of your illness or injury  
e.g. ill-health pension, insurance payments.

Yes

No

Insurance payments - name of insurer(s)	Cover	Income amount £ and frequency	Start Date
			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>
			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>
Pension - name of pension provider(s)			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>
			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>
Other - name of source(s)			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>
			<div><div>D</div><div>D</div><div>M</div><div>M</div></div>

**Section 4 - Your health**

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

a. When did symptoms first occur?

D D M M Y Y Y Y

What were these symptoms?

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

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. a. Are you using any physical aids e.g. walking sticks or collars? Yes No  
b. 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

County

Postcode

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

Name

Address

City

County

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

County

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

County

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

2. Have you discussed returning to work with your GP? If 'Yes', please give details.

Yes

No

**Section 6 - Declaration and consent - this declaration should be returned to MetLife****Employee's personal details**

Name

Address

City

County

Postcode

Date of birth

D D M M Y Y Y Y

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.

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 a 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](http://www.metlife.co.uk).

Should you have any questions or concerns, please contact the MetLife Data Protection Officer at [DataProtectionUK@MetLife.com](mailto:DataProtectionUK@MetLife.com).

**Declaration and consent**

By signing below, I confirm that I have read and I understand the explanation above of my rights under the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (as applicable).

I consent to MetLife applying to my treating Doctors or medical practitioners to obtain medical reports and my medical notes and records.

I do want to see any medical report before it is sent to MetLife      I do not want to see any medical report before it is sent to MetLife.

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 or electronic copy of this form and the signed consent shall have the same validity as the original.

I declare that the information disclosed by me in this claim form is true, accurate and complete. I understand that if I have provided misleading information it may result in the claim being rejected.

I confirm that I have read the Data Protection Notice above and have understood the purposes for which my personal data and sensitive personal data will be stored and processed by MetLife. I consent to MetLife processing or sharing my personal data and sensitive personal data with the policyholder (if applicable), my treating doctors or medical practitioners or independent medical practitioners appointed by MetLife, other insurers, MetLife's parent company and other companies within the company group, MetLife's successors and assigns, to insurance intermediaries and MetLife's service providers, to the contractors or sub-contractors of their service providers, to reinsurers, or to third party companies for the purposes identified in the notice.

Name of employee

Date of signature

D D M M Y Y Y Y

Please sign here

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*For every moment, there's*  **MetLife**