MetLife Claims
PO Box 1411
Sunderland
SR5 9RB

0800 917 1333
www.metlife.co.uk
claims@metlife.uk.com

Claim form

In order to make a claim under MetLife MultiProtect or Accident Protection, please complete this form in full. Should you have any queries completing the form, please contact your claims team on the telephone number above.

Please note that the issue of this claim form by MetLife Europe d.a.c. ('MetLife') does not constitute an admission of any liability by MetLife in respect of your claim under your policy. 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 your claim. If you provide misleading information it may result in your claim being rejected. If the requirements under our claims procedures are not complied with, we may not pay your claim. Please refer to the policy Terms and Conditions for claim that are excluded from cover.

Before submitting your claim form, please ensure you have:

- ☐ Signed the declaration and consent
- ☐ Filled out your bank details (if the claim is not being paid to the account we collect premiums from)
- ☐ Filled out your section of your claim form
- ☐ Asked a Doctor to fill out the Medical Statement
- ☐ Provided a copy of the hospital discharge summary (if relevant)
- ☐ Provided proof of your main occupation (in the case of sports-related injuries – please see notes on page 6)

Policyholder Name: | Policy Number: | BPA number:

This claim form is for Accident Protection and MultiProtect claims

Section 1 - Declaration and consent

Access to medical reports

It may be necessary for us to ask any Doctor who has attended to 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 your 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 your 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

Name of claimant

Date D D M M Y Y Y Y

Please sign here

Please note: 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 your claim. If you provide misleading information it may result in your claim being rejected.

By signing above, I confirm that 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 want to see any report before it is sent to MetLife ☐ I do not want to see any 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 confirm that I have read the Data Protection section above and understand how to access MetLife's Privacy Notice.

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 my claim being rejected.

Section 2 - Bank account details - to be completed by you

Following our assessment of your claim, any claim payment would automatically be made direct to the bank account we collect premiums from. Payment should clear within 3 working days of MetLife confirming payment has been made.

If you prefer that we pay the benefit into a different bank account to your premium bank account, please complete the details below. Please note, you do not need to complete this section if we are paying the benefit into your premium bank account.

Name of Bank/Building society

Address

City Postcode

Bank account number Sort code - -

Name of bank account Holder

If you request we make payment to a bank account that is not yours we will require proof of identification (Driving License, Passport or National Identity card) from the bank account holder.

Section 3 - Details of Claim

Please only complete your address here if you have moved since taking out your policy and we don't have your new address.

Address

Town/City

Postcode

Email

(Please note that by giving us your email address, you agree to us updating you on your claim by email and contacting you about our processes)

Mobile number

Home telephone number

What is your preferred method of contact? ☐ Email ☐ Telephone ☐ Post ☐ SMS Text

General Practitioner (GP)

Title

☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other - please specify

First name(s)

Surname

Address

City

Postcode

Telephone number

Name(s) of any other treating medical professional (for your injury or illness you are claiming for)

Title

☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other - please specify

First name(s)

Surname

Address

City

Postcode

Telephone number

Please confirm who you have asked to complete the medical statement

Accident Claims

If you are claiming for an accidental injury please complete this section.

If you are only claiming for UK Hospitalisation benefit due to sickness, please move to page 7 and complete that section.

Date of accident | | | | | | | | | Time

Please tell us what happened

Where did this accident happen?

What injuries are you claiming for?

If you were provided with a hospital letter, a copy of your xray or MRI scan please send this to us.

If the accident occurred whilst playing sport, please confirm:

Type of sport

Team name

Important

Do you get paid to play this sport? ☐ Yes ☐ No

If you get paid to play this sport please can you provide a copy of a payslip from your main occupation so that we can confirm you are not a professional sportsperson.

For accidents reported to the police

If the accident was reported to the police, please state the address of the police station, and any crime reference number you may have been given:

Address

City | Country | Postcode

Police Officer first name(s) | Surname

Telephone number

Crime reference No.

UK Hospitalisation claims – Accident and Sickness

Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name

Why were you admitted to hospital?

Policyholder Name: | Policy Number: | BPA number:

This claim form is for Accident Protection and MultiProtect claims

To be completed by you:

Full name

Claiming for

Section 4 - Medical Statement - to be completed by the Doctor

Full name of the patient

Date of birth D D M M Y Y Y Y

Diagnosis (include details of any changes to diagnosis)

Date of first consultation D D M M Y Y Y Y

Last consultation D D M M Y Y Y Y

Total number of consultations

Date symptoms first appeared D D M M Y Y Y Y

Date diagnosed D D M M Y Y Y Y

Who made the diagnosis?

How was the diagnosis made?

If the diagnosis was made via clinical examination rather than a diagnostic tool such as test, xray, scan, what symptoms supported the diagnosis?

What treatment has your patient received? If surgery has taken place/is planned please include details of the surgery.

If this was an accidental injury please advise how the accident happened and all the injuries sustained.

Policyholder Name: Policy Number: BPA number:

This claim form is for Accident Protection and MultiProtect claims

Has the patient been admitted to hospital for 24 hours or more in relation to this illness or injury? ☐ Yes ☐ No

If 'Yes' please provide details

Admission date	Admission time	Discharge date	Discharge time	Hospital name and town	Ward name

Has the patient been referred to any other Doctor or specialist for treatment or advice in relation to the condition they are claiming for?

☐ Yes ☐ No

If 'Yes' please provide details below:

Name

Address

City Country Postcode

Work telephone number

Name

Address

City Country Postcode

Work telephone number

Please provide details of any prior medical history for your patient that might relate to the current claim

Please advise the type of break sustained (if more than one bone is broken please confirm details of each break)

Is the break (or each break if applicable) a complete break involving the entire width of the bone?

If the bone is bruised, please advise whether this is intraosseous or periosteal bruising

Please use this space to provide any further information you feel is relevant or would assist us with your patient's claim

Please return this form with copies of your patient's medical records and hospital letters related to this illness or injury.

Policyholder Name: Policy Number: BPA number:

This claim form is for Accident Protection and MultiProtect claims

Section 5 - Declaration - to be completed by the Doctor

I declare that I am the patient's GP / treating medical practitioner / specialist* and the information given in section 4 is true, accurate and complete. (*delete as appropriate)

With this form I am sending a copy of the requested medical reports. I declare that, in my opinion, there is nothing in the enclosed medical reports which would be likely to cause serious harm to the physical or mental health of the claimant or any other individuals, and any content which would be likely to cause such harm has been removed from the enclosed reports. I understand that if MetLife receives a subject access request from the claimant, it may be required to disclose the enclosed medical reports.

Print Name

Date D D M M Y Y Y Y

Please sign here

Address

Telephone number

City

Country

Postcode

Practice or Hospital Stamp

Email Address

Section 6 - Payment of fees for providing medical information - to be completed by the Doctor

Your patient holds a policy with us under which they wish to make a claim. The claim assessment requires us to request medical information including but not limited to medical notes, copy correspondence, copies of discharge letters, X-rays, MRI scans, test results, as well as responses to specific reports and questions.

Full and accurate responses to all of our requests are required to enable us to complete our claim assessment. We appreciate that it may be appropriate for a reasonable professional fee to be charged associated with the provision of medical information in accordance with those agreed with the British Medical Association (BMA). MetLife confirms that it will be responsible for the payment of this fee.

In order for us to arrange to pay you the fee to provide the medical information requested, please either issue an invoice for this fee to MetLife (sending the information requested at the same time) or complete the details below and send us under separate cover the information requested.

If there are any questions around the provision of the information or payment of the medical fee please contact us on 0800 917 1333.

Payment instructions

Title

☐ Dr ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other - please specify

First name(s)

Surname

Name of account holder

Address

City

Postcode

Account number

Sort code - -

Fee charged for provision of medical information

Please note we prefer to make payment by direct credit to ensure a quick and secure payment. If payment is to be by cheque please just fill out name of account holder and amount.

If the policyholder has paid this fee, please tick the box below and provide the policyholder with a receipt so we are able to reimburse them.

☐ Fee paid by policyholder

Please return this form and all requested medical and supporting documentation to:

MetLife, Individual Claims, PO Box 1411, Sunderland, SR5 9RB

Policyholder Name: Policy Number: BPA number:

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Tel: 0800 917 0100 **metlife.co.uk/multiprotect**

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