MetLife

MetLife disability appeal request

Important: You may return this form to request an appeal review.

Metropolitan Life Insurance Company

Instructions

- This form should be submitted with any request for a review of our claim decision.

For efficient and prompt claim handling, all documents or correspondence returned to us should contain the claim number.

SECTION 1: Claim information

Employee

Claim #:		Date:
First name	Middle name	Last name

Employer:

SECTION 2: Request for claim review

- You may use the space below to indicate why you believe our claim determination was incorrect.
- You may attach additional pages or information, if it is pertinent to your request.

SECTION 3: Signature

Signature | Date *(mm/dd/yyyy)*

Print name

SECTION 4: How to submit this form

Mail:

Metropolitan Life Insurance Company

MetLife Disability
P O Box 14592
Lexington, KY 40511-4592

Fax:

1-844-380-0569

Email:

DisabilityAppeals@metlife.com