MetLife®
Metropolitan Insurance Company
PO Box 14590
Lexington, KY 40515
Fax: 1-800-230-9531

Medical Substantiation Form
American Airlines, Inc. Post-Pregnancy Maternity Short-Term Disability Plan

Instructions for completing the Medical Substantiation Form:

1. This form must be completed and signed by a legally licensed physician or medical practitioner performing services within the scope of that license, including an M.D., nurse practitioner, or physician's assistant.
2. Complete all applicable areas of the claim form. Please print clearly.
3. Please sign the form where required.
4. Faxing this form will expedite receipt and eliminate your need to mail it.
5. Please call MetLife at (888) 533-6287 with any questions.

Section 1: To Be Completed by Employee			
Employee Name (Please Print)			Home Phone #
Employee Address	City	State	Zip Code
We require a street address for our records if a P.O. Box is your mailing address			
Date of Hire or Company Seniority Date	Employee ID #		
Job Title			
Employee Signature			Date

Section 2: To Be Completed by Medical Practitioner **This report is to assist us in making a disability determination that impacts income replacement for your patient.** **A MetLife claim representative may telephone your office if additional information is needed.**			
Patient Name			
Delivery date	Type of delivery		
Is the patient currently unable to perform job duties due to physical or mental limitations resulting from pregnancy and/or delivery? ☐ Yes ☐ No			
If yes, how long, in your opinion, will the patient to be unable to perform the duties of her job due to physical or mental limitations resulting from pregnancy and/or delivery? *NOTE: The American Airlines, Inc. Post-Pregnancy Maternity Short-Term Disability Plan offers coverage of up to* ***10 weeks*** *immediately following delivery, if the patient's medical practitioner determines that the patient remains unable to perform job duties due to the physical or mental limitations resulting from pregnancy and/or delivery.* ☐ 2 Additional weeks; ☐ 4 Additional weeks; or ☐ Other. Please indicate the number of additional weeks required for recovery _____.			
Medical Practitioner's Name (Please Print)		Specialty	
Address	City	State	Zip Code
Email Address	Phone #		Fax #
Medical Practitioner's Signature		Date	