MetLife

American Life Insurance Company
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Group Medical Claim Form

In-patient	☐
Out-patient	☐
Maternity	☐
Optical	☐
Dental	☐
Group Critical Illness or Disability	☐

Policyholder's[1] Name:
Group Policy Number: **BGL-**
Insured's Office ID Number:

This section to be filled by the Claimant [2]

1. Claimant's Name : ______
2. Claimant's Date of Birth: ______
3. Patient's Name: ______
4. Patient's Date of Birth: ______
5. Patient's Relation with Employee : ______
6. Nature of Sickness/Accident : ______
7. Total Amount Claimed: ______

Authorization

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide MetLife (American Life Insurance Company) with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Claimant's Name: ______

Claimant's Signature: ______ Date: ______

Mobile No. : ______ Email : ______

Employer's Section

1. Are all required documents checked and attached? ☐ **Yes** ☐ **No**
2. Cheque Payment made in the name of
   - ☐ **Employee**
   - ☐ **Employer (Provide request letter)**
   - ☐ **Assigned Provider (Provide request letter)**

Employer's Authorized Person's Signature & Seal : ______ **Date:** ______

Claim Submission Instructions

- Please submit separate claim forms for each insured and for different benefit type (Out-patient / In-patient / Maternity / Dental / Optical / Policy Year).
- Submit all necessary claims documents within 30 (thirty) Days from the incurred date.

Please attach following documents with this Claim Form

Out-Patient Treatment

- Original money receipt showing the attending physician's detailed charges along with his stamp and signature.
- Original itemized pharmacy bill showing the date of purchase, name of patient, quantity and name of drugs along with photocopy of physician's prescription.
- Original receipt showing charges for each of the Laboratory tests and other examinations done, supported by the respective physician's request to undergo examinations and photocopies of the results of examinations undertaken.

In-Patient Treatment

- Itemized original hospital bill supported by the official receipt for the total amount paid.
- Original receipt showing attending Physician's/Surgeon's charges along with his stamp and signature.
- Photocopy of detailed hospital discharge report.

For Critical Illness or Disability Benefit, Age Proof must be submitted. Any of the following documents is accepted as Age Proof:

- **Photocopy of National ID Card**
- **Photocopy of Passport**
- **Photocopy of Driving License**
- **Photocopy of Certificate of S.S.C or equivalent examinations**

N.B Company may ask for additional information and documents, if deemed necessary.

1. Policyholder: The Institution which purchases or owns the policy
2. Claimant: Beneficiary. The person/ entitywho is named to receive the Insurance Policy Benefit.

CL-4

American Life Insurance Company is incorporated in the USA as a limited Company