MetLife

American Life Insurance Company
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METCL1501

Individual Life Accident/Sickness Claim Form

Sickness Claim	☐
Accidental Claim	☐
Critical Illness Claim	☐
Permanent Disability Claim	☐
Partial Disability Claim	☐
Continued Disability or Waiver of Premium Claim	☐

(This form must be filled out by the Policyholder [1]. If the Policyholder is disabled, any close relative should fill.)

Policy Number(s): _____
(Please mention numbers of all MetLife policies possessed by the policyholder)

1. Policyholder's Name: _____
2. Insured's [2]/Patient's Name: _____
3. Policyholder's Present Contact Address: _____
4. Mobile/ Phone Number: _____ Alternate Mobile/ Phone Number: _____ E-mail: _____
5. Type of Accident/ Sickness: _____
6. Date of Accident/ Sickness _____

Payment Instruction (Upon Approval of Claim) [3]

Please select a method for payment of your claimed amount:

☐ Electronic Fund Transfer (EFT) ☐ Account Payee Cheque ☐ Pay to authorized person/ organization

If you do not have a bank account, you may authorize a person / company other than a MetLife Representative to receive the payment by providing proof of relationship * / ownership *.

Name of authorized person/ organization and relationship with policy owner _____

*Payment to proposed recipient (other than the Policy Owner) is subject to company's approval.

Authorization

I hereby certify that the foregoing statements are full and true to the best of my knowledge and I hereby authorize all physicians, hospitals, clinics, pharmacists, laboratories, employers and any institution or any other person who has any record or information about me and/or any of my insured family members to provide MetLife (American Life Insurance Company) any and all information with respect to medical history, consultation, prescription or treatments and copies of all hospital or medical records. Any copy of this authorization shall be taken as original.

Policyholder's Name: _____ Signature: _____ Date: _____

Please attach following documents with this Claim Form

1. Photocopy of Hospital Discharge Certificate with proper diagnosis, detailed case summary and daily follow-up notes along with the itemized hospital bill (if any) to be issued and signed by the Hospital Authority.
2. Photocopy of registered (minimum MBBS) Doctor's prescription with proper diagnosis of Sickness/ Accident.
3. Photocopy of all diagnostic / investigation reports advised by the respective physician.
4. Photocopy of imaging reports (Like X-Ray, MRI or CT Scan, etc. where applicable).
5. All original Bills and Vouchers (for Accidental Claims) and original Itemized Hospital Bills (for Surgical Benefits).
6. For Critical Illness or Disability Benefit, Age Proof must be submitted. Any one 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**
7. Photocopy of a blank cheque leaf (MICR) (For EFT payments only).

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

1. Policyholder: The person/entity who purchases or owns the policy
2. Insured: The person whose life/health/liability is insured under a life insurance policy
3. Upon approval of the claim, we will send the claimed amount to your bank account via EFT (as per the details of the cheque leaf provided by you). If there is no arrangement for EFT; we will issue acoount payee cheque favouring you and send that via postal services.