MetLife℠

American Life Insurance Company
MetLife Building, 18-20 Motijheel C/A
P. O. Box 9, Dhaka-1000, Bangladesh.

CREDIT LIFE DEATH / DISABILITY CLAIM FORM (CREDIT CARD)

POLICY NO.: **BGL-**

NAME OF INSURED _____
(Primary Cardholder)
CREDIT CARD NUMBER_____ **CARD A/C NUMBER** _____

BENEFICIARY'S STATEMENT

1. Date of Birth of Insured — D D | M M | Y Y Y Y
2. Place of Birth _____
3. Occupation at time of Death/Disability _____
4. Date last worked full time (if applicable) _____
5. What is your relationship to the insured? _____
6. Family Contact Person _____
7. Address _____

Contact Number _____

PHYSICIAN'S STATEMENT (Must be filled by the Physician's own handwriting)

6. Date of Death/ Disability — D D | M M | Y Y Y Y
7. Place of Death/ Disability _____
8. Interval between onset of illness/injury and Death/ Disability _____

9 a. **Disease or condition directly leading to Death/Disability:** (This does not mean the mode of dying, such as Heart Failure, Asthma etc. It means the disease, injury or complication which caused Death/ Disability.) _____

9 b. If Death/ Disability was due to accident, suicide of homicide, **specify** which and **describe** briefly: _____

_____

10. Did the deceased/ disabled person receive treatment from YOU or to best of your knowledge, from any other physician, or in any Hospital or institution during the last 5 years? (If YES to either question, please mention the Name, Address, Dates, and Nature of illness/injury) _____

_____

Name, Address, Signature and Seal of Attending Physician

Name:

Address: _____ Signature & Seal

AUTHORIZATION

I hereby certify that the foregoing statements are full and true to the best of my knowledge and hereby authorize, on behalf of the Cardholder, all physicians, hospitals, clinics, pharmacists, laboratories, employers and any institution or any other person who has any record or information about the deceased/disabled Cardholder to provide American Life Insurance Company (MetLife) 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 the original copy.

Policy holder Beneficiary _____ Authorized Signature _____ Date _____

Beneficiary _____ Signature _____ Date _____

Witness _____ Signature _____ Date _____

POLICYHOLDER'S STATEMENT

Notice is hereby given of the Death/Disability of (Name) _____ of (Address)_____

a Cardholder of this Bank with Card Account Number_____ since _____who was enrolled into the Group Insurance Scheme on _____. We hereby warrant that such insurance was in force at the Date of Death/Disability and that the said Cardholder was in our list of Insured Cardholderdated _____ for BDT_____ (Last Statement Balance for which Premium was Paid) and also certify that the Outstanding Balance, as per Policy Terms, is BDT_____.

Date _____ 20 _____

_____
Authorized Signature and Official Seal