MetLife[SM]

MetLife Building, 18-20 Motijheel C.A.
P.O. Box 9, Dhaka-1000
Bangladesh

P. R. Date : .....
Tk. .....

LONG FORM APPLICATION AND HEALTH CERTIFICATE FOR ☐ Reinstatement ☐ Change in ☐ Plan ☐ Addition of Benefits ☐ Removal or Reduction in Rating ☐ Amount

AGENCY ..... POLICY NO ..... DUE DATE .....

PART 1- QUESTIONS TO BE ANSWERED BY POLICYOWNER

1.	NAME	DATE OF BIRTH	HEIGHT	WEIGHT
INSURED				
OWNER				
SPOUSE				
DEPENDENT (S)				

2. A. Present Occupation of Owner ..... B. Occupation of Spouse .....
   C. Exact Daily Duties .....
   D. Employer's Name & Address .....
3. A. Smoking (day/week by the insureds) .....
   B. Alcohol consumption (day/week by the insureds) .....
4. Has any of the insureds now or do they expect to have any connection with
   A. Military or Naval Service ☐ Yes ☐ No
   B. Aerial Navigation or Piloting ☐ Yes ☐ No
5. A. Are the Insureds negotiating or contemplating to negotiate for other Life Insurance ? ☐ Yes ☐ No
   B. Since date of your application for the above mentioned policy, have the insureds applied, either formally/informally, for new insurance, change of plan or reinstatement which was declined, postponed, withdrawn/modified in kind, amount, or rate ? ☐ Yes ☐ No
   If so, state to what companies, date and cause .....
6. A. Since that date , have any deaths occured in the family of the insureds ? ☐ Yes ☐ No
   B. If so, state relationship, age and cause of death .....
7. Since date of your application for the above numbered policy, has any of the insureds
   A. Been ill or injured ? (Give all dates and details) ☐ Yes ☐ No
   B. Consulted or been treated by anyone on account of the insureds health or their physical or mental condition ? (Give all dates & details) ☐ Yes ☐ No
   C. Been a patient in any hospital or sanitarium ? ☐ Yes ☐ No
8. Females only : are you now pregnant ? (If yes, how many months) ☐ Yes ☐ No
9. Are all the insureds now in good health ? (If no, explain in details) ☐ Yes ☐ No
10. Does any of the insureds intend to seek medical advice, treatment or have any medical treatment tests performed ? ☐ Yes ☐ No
11. Other Insurance Policies including Policies with MetLife Alico

POLICY NO.	COMPANY	AMOUNT	SUPPLEMENTARY CONTRACTS

12. AIDS (Acquired Immune Deficiency Syndrome). Describe in detail any affirmative answers.
   A. Have you or any of the insureds received medical advice, or treatment in connection with AIDS or an AIDS related condition or a sexually transmitted Disease ? ☐ Yes ☐ No
   B. Have you or any of the insureds been told that you had AIDS or AIDS related complex ? ☐ Yes ☐ No
   C. Have you or any of the Insureds been told that you had a positive blood test for antibodies to the Acquired Immune Deficiency Syndrome (AIDS) virus ☐ Yes ☐ No
   D. Do you or any of the insureds have any of the following which are unexplained : Fatigue, Weight Loss, Diarrhea, Enlarged Lymph Nodes, or Unusual Skin Lesion ? ☐ Yes ☐ No

If the answers to any of the above question is yes, identify question number and include diagnoses, dates, duration, degree of recovery or results and names and addresses of all the attending physicians and medical facilities and any other details as required.....

.....

I declare that each of the above answers is full, complete and true, and agree that they shall be taken as basis of the reinstatement, change or issue of the above insurance and that such reinstatement, change or issue shall not be considered as effected by reason of any cash paid or settlement made in payment of or on account of the amount now due untill this application shall be duly approved by the company and that receipt, retention, deposit or cashing of any such payment or settlement by the Company or its agent shall not constitute a waiver of forfeiture or otherwise affect this condition. Also, I understand that, notwithstanding any provisions to the contrary in said policy, the period of two years mentioned in the incontestability and self-destruction provisions thereof shall, in the event of reinstatement of said policy, be deemed to run from date of such reinstatement.

Amount paid with this Application : .....

Signed at ..... (City) This ..... day of ..... 201 .....

Full Name & Signature of the Applicant
Phone (if any) .....

Name & Signature of the Agent/Medical Examier with SEAL and ID No.

Please Turn Over

PART II : MEDICAL EXAMINATION

IMPORTANT : PLEASE CHECK IDENTITY OF INSURED

Type of Identification : ..... Number ..... Signature of Insured .....

1. A. How long have you known the Insured ? ..... B. Are your related ? ..... C. Race .....

2. A. Height ..... Ft ..... Ins C. Did you { Weigh him / her ? ❑ Yes ☐ No D. Grith (males only) { Chest Forced Expiration ..... Ins
   B. Weight ..... Lbs { Measure him / her ? ☐ Yes ☐ No { Chest Fu l Inspiration ..... Ins
   Abdomen at Umbilicus ..... Ins

	Yes	No
3. Does inquiry or examination reveal any past or Present disease of **brain, chest, digestive, genito-urinary, cardiovascular, renal, glandular or nervous system ?** (Give details)		
4. A. Is his appearance unhealthy ?		☐
B. Does he appear older than age given ? (Why)	☐	☐
C. Is there any impairment of sight or hearing ?	☐	☐
D. Are pupillary and patellar reflexes abnormal ?	☐	☐
E. Is there any deformity or other physical defect ?	☐	☐
F. Has serological test for syphilis ever been made ? (Give reason, date and result)	☐	☐
G. Are there any abdominal varicostes or hernias ? (Locate, describe in details)	☐	☐
H. Do you know anything about his character, habits or morals which would affect the risk adversely ?	☐	☐

10. Name and Address of this Medical Examiner
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DETAILS (Mention Ref. Question Number)

5. Pulse per-minute

Rate at rest	* After excercise	5 minutes later

* (25 beats above resting)

Irregularities per-minute

6. Blood Pressure

Systolic	Diastolic (5th phase)

7. Is there any evidence of arteriosclerosis or aneurysm ? ❑ Yes ☐ No

8. Is there { a heart murmur ? ..... / any hypertrophy ? ..... } Describe in detail

9. A. Urinalysis

Specific Gravity	Sugar	Albumin

B. Are you satisfied that the specimen is authentic ? .....

Dated at .....
(City)
this ..... day of ..... 201 .....

..... M. D.
Signature of Medical Examiner with SEAL and ID No.

FOR HEAD OFFICE USE ONLY

Referred to Underwriting Dept. on Account of .....

By ..... Date .....

UNDERWRITING COMMENTS : .....
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