MetLife℠

American Life Insurance Company
Metlife Building, 18-20 Motijheel C.A.
P.O. Box 9, Dhaka-1000
Bangladesh
Tel : 9561791, Fax : 9558682

GROUP MEDICAL CLAIM FORM

(A) CLAIM SUBMISSION PROCEDURE

To avoid any delays in the processing of your claim please ensure that:

1. The claim is submitted through your Employer. Please obtain the Group Policy No. and your Certificate No. from your Employer.
2. All questions on the form are answered. Do not leave any blanks. Please use BLOCK LETTER.
3. All submitted claim documents are in English.
4. All necessary claims documents are submitted within 30 (thirty) DAYS from the incurral date.
5. The following original documents are attached:

(a) Out-Patient Treatment

i) Original money receipt showing the attending physician's detailed charges alongwith his stamp and signature
ii) Original itemized pharmacy bill showing the date of purchase, name of patient, quantity and name of drugs alongwith photocopy of physician's prescription.
iii) Original receipt showing charges for each of the Lab. Test, X-ray Films, and other examinations done and supported by the respective physician's request to undergo examinations and copies of the results of examinations undertaken.

(b) In-Patient Treatment

i) Itemized original hospital bill supported by the official hospital receipt for the total amount paid.
ii) Original receipt showing attending Physician's/Surgeon's charges alongwith his stamp and signature.
iii) Photocopy of detailed hospital discharge report.
iv) Photocopy of MetLife Hospitalization Insurance Card.
v) Photocopy of MetLife pre-approval for non emergency hospitalization.

(B) EMPLOYEE'S SECTION

1. Employee's Name/Date of Birth/CS or Code No. : _____
   (As shown on G-42 Health Statement Form)
2. Patient's Name/Date of Birth/Relation with Employee : _____
   (As shown on G-42 Health Statement Form)
3. Group Policy No. : _____
4. Individual Certificate No. : _____
5. Patient's Effective Date of Coverage : _____
6. Nature of Sickness/Accident : _____
7. Dependent Code : _____
8. Physician's/Surgeon's Tel. No. & Complete Mailing Address : _____

_____

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 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.

Employee's Signature _____ Date _____ Mobile No. _____

(C) EMPLOYER'S SECTION

1. Is this claim arising out of the patient's occupation? ☐ Yes ☐ No
2. Are all required document checked and attached? ☐ Yes ☐ No
3. Cheque payment made in the name of :
   ☐ Employer
   ☐ Employee
   ☐ Assigned Provider _____
4. Total Amount Claimed : _____
5. Employer's Claim No. : _____
6. Employer's Representative Signature : _____
7. Employer's Stamp : _____ Date _____