



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

Tel : (880-2) 9561791
 Fax : (880-2) 9558682
 www.metlife.com.bd

Individual Life Accident/Sickness Claim Form

Sickness Claim	<input type="checkbox"/>
Accidental Claim	<input type="checkbox"/>
Critical Illness Claim	<input type="checkbox"/>
Permanent Disability Claim	<input type="checkbox"/>
Partial Disability Claim	<input type="checkbox"/>
Continued Disability or Waiver of Premium Claim	<input type="checkbox"/>

(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 First Name _____ Last Name : _____ Date of Birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

2. Insured's ²/ Patient's First Name _____ Last Name : _____ Date of Birth

	D	M	M	Y	Y	Y	Y
--	---	---	---	---	---	---	---

3. Policyholder's Present Address : House/Village : _____ Road No. : _____ Block No. : _____
 Post Office : _____ Police Station : _____ District/City : _____ Country : _____

4. Mobile/ Phone Number :

--	--	--	--	--	--	--	--	--	--

 e-mail : _____

5. Type of Accident/ Sickness : _____ 6. Date of Accident/ Sickness

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Payment Instruction (Upon Approval of Claim)³

1. Bank Account Name : _____ 2. Bank & Branch : _____
 3. Bank Account Number :

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

 4. Routing Number :

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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 _____

If authorized person, please mention relationship with Policy Owner : _____ Date of Birth

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

* 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 - AMR) and original Itemized Hospital Bills (for Surgical Benefits).
6. Photocopy of blank MICR cheque leaf/ Bank Statement of Policy Owner/assignee

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 account payee cheque favouring you and send that via postal services.