Loss of Life Claim Form

Claimant's Statement

This form should be duly completed and signed by each and every major beneficiary separately. Photocopy of this form may be use when required.

American Life Insurance Company
WILMINGTON, DELAWARE, U.S.A., INCORPORATED 1921

GULF OPERATIONS
P.O. Box 371916, Dubai, United Arab Emirates

A. INSURED DETAILS

A1. Deceased's Full Name _____ Date of Birth D D M M Y Y Y Y

Policy Number(s)	Coverage Amount(s)	Currency(ies)

All policies listed above should be submitted with your claim except those where the claim is made under Waiver of Premium Benefit.

A2. Date of loss of life D D M M Y Y Y Y Place of loss of life ☐ Residence ☐ Hospital / Clinic ☐ Work Place

☐ Others, please specify _____

A3. Cause of loss of life _____

A4. Since when has the insured suffered from this condition

_____

A5. Occupation at date of loss of life _____

A6. Employer's Name _____

A7. Employer's full address _____

P.O. Box _____ City / Countries _____

A8. Telephone No Country Code – Area Code – _____ E-mail _____

A9. When did the deceased first complain of, or give other indications of his / her last illness (date) D D M M Y Y Y Y

A10. When did the deceased first consult a physician for his/her illness (date) D D M M Y Y Y Y

A11. Date the deceased last attend to his/her usual work (last working date) D D M M Y Y Y Y

A12. Was the Insured smoking? ☐ **YES** ☐ **NO**

If 'YES', How many cigarettes he used to smoke per day and since when? _____

A13. Full Name and addresses of all physicians who examined the Insured during his / her last illness and during the five years prior thereto:

Full Name	Address	Date of Attendance	Illness or Condition

A14. In what other company(ies), and for what amounts, was the life of deceased insured?

Comapany(ies)	Policy Number(s)	Policy Date	Coverage Amount

B. CLAIMANT / BENEFICIARY INFORMATION

B1. Full Name of Applicant / Beneficiary

B2. Relationship to the Insured | Date of Birth D D M M Y Y Y Y | Age Last Birthday

B3. City of Birth | Country of Birth

B4. Please list all Nationalities: 1) 2) 3)

RESIDENCY*

1) 2) 3)

***** ***"Residency"*** *is any place where you may be obliged to file income tax returns as a resident of that jurisdiction.*

B5. OCCUPATION

Employment Status ☐ Employee ☐ Self-employed

Position / Title | Exact Daily Duties

Company Name | Nature of Business

Telephone Country Code – Area Code – | E-mail

B6. CURRENT RESIDENCE ADDRESS

Country | City / Town | P.O. Box

Area / Street | Building | Flat / Villa No.

Telephone Country Code – Area Code – | Mobile Country Code – Area Code –

B7. IN WHAT CAPACITY OR BY WHAT TITLE, DO YOU CLAIM THIS INSURANCE?

☐ **Designated Beneficiary**

☐ **Legal Guardian** *(please provide legal Guardianship Certificate from appropriate authority with the right to cash proceeds and give valid discharge)*

☐ **Successor / Legal Heir** *(please provide legal succession Certificate from appropriate authority appointing he legal heirs of the deceased with their names, ages and shares)*

☐ **Other** *(Please specify)*

B8. PREFERRED MODE OF PAYMENT

☐ Wire Transfer* ☐ Cheque ☐ Demand Draft*

**Please complete the attached bank detail form in case of Demand Draft or Wire Transfer.*

The undersigned, hereby makes claim to said insurance, and agrees that the written statements and affidavits of all physicians who attended to or treated the insured shall constitute and they hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said Company shall not constitute nor be considered by it that there was any insurance in force of the life in question, nor a waiver of any of its rights or defenses.

Dated at City Country on this D D day of M M 20 Y Y

Signature x Claimant / Beneficiary

AUTHORIZATION

I, Full Name Of Claimant / Beneficiary

give my permission to release information concerning full name of insured who died on (Date of Death) to MetLife including its agents, subsidiary companies and attorneys, reinsures, insurance support group and independent investigator who are acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS related disease, mental illness, drug or alcohol use, smoking history, other insurance coverage, financial and employment history. This information may be released by medical professionals or facilities, pharmacies, Hospitals, prescription data base suppliers, government offices, employers, insurance companies or any other organization or person having any knowledge of the above named insured. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. I understand that my claim will not be processed unless this authorization is completed and signed. This authorization is valid from the date signed until the claim is resolved.

DECLARATIONS

a) I hereby authorize MetLife to send me notifications and notices via short message service "SMS" and I accept receiving SMS and understand that MetLife makes no warranty that the SMS will be uninterrupted or error free and any such error or interruption shall not be deemed or treated in any way whatsoever to create any liability on MetLife and I acknowledge that I shall not file any complaint or claim against MetLife for any SMS error or interruption or for any reason related to receiving / not receiving SMS.

b) I also understand that the issuance and continuation of my insurance contract is subject to the regulations applicable to the Company with respect to the international sanctions and I hereby agree that for the purpose of complying with the local and international sanctions including but not limited to the OFAC, UN sanctions, the Company may at its own discretion take any action that it finds appropriate with respect to the issuance, freezing any transaction on my insurance policy, and / or continuation of my insurance policy.

c) I hereby grant MetLife my unambiguous consent, to process, share and transfer my Personal Data* to a recipient inside or outside this country (including but not limited to MetLife Inc. and / or American Life Insurance Company's Headquarters and their branches, affiliates, reinsurers, business partners and/or to any actual or potential assignee, novatee or transferee of MetLife) where the processing, transferring or sharing of my Personal Data is requested by any of the above mentioned recipients or necessary or required for the performance of MetLife's obligation under this application and/or the insurance policy, or to comply with any obligation which MetLife is subject to.

*Personal Data means all information relating to me (whether marked "personal" or not) disclosed to MetLife by whatever means either directly or indirectly which concerns, including but not limited to, my medical conditions, treatments, prescriptions, business, operations, contact details, account balances/activities or any transactions undertaken with MetLife."

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) DECLARATION:

The Insured/Owner consents to MetLife, its officers and agents disclosing any Confidential Information to:

(i) any group member and representatives of MetLife in any jurisdiction (together with MetLife, the "Permitted Parties");

(ii) Any persons as required by any law (including but not limited to the U.S.A Foreign Account Tax Compliance Act) or authority (including but not limited to the U.S.A Internal Revenue Service) with jurisdiction over any of the Permitted Parties;

(iii) professional advisers, insurer, reinsurer or insurance broker and service providers of the Permitted Parties who are under a duty of confidentiality to the Permitted Parties;

(iv) any actual or potential assignee, novatee or transferee in relation to any of MetLife's rights and/or obligations under this Policy (or any agent or adviser of any of the foregoing); and

"Confidential Information" means all information relating to the Insured/Owner (whether marked "confidential" or not) disclosed by whatever means either directly or indirectly to MetLife which concerns the business, operations or customers of the Insured/Owner (including but not limited to contact details, tax identification number/social security number, account balances/activities or any transactions undertaken with MetLife).

MetLife will deduct any withholding required by the US Foreign Account Tax Compliance Act ("FATCA").

MetLife reserves the right, within its sole discretion, to terminate the Policy in the event that appropriate documentation of Insured's/Owner's US or non-US status for purposes of FATCA is not timely provided to MetLife. In particular, in the event that applicable local laws or regulations would prohibit withholding on payments to the account or prohibit the reporting of the account, and no waiver of such local law is obtained, MetLife reserves the right to close the account.

E-MAIL DECLARATION:

By providing your E-mail address and signing this application you agree to receive the policy document, certificate and / or any other documents ["Documents"] via electronic mail ["E-mail"]. Please be aware that having chosen this electronic delivery of Documents, it is your responsibility to ensure that the E-mail address you have provided us is correct at all times.

MetLife is not responsible for non-receipt of E-mails due to invalid E-mail addresses or other technical problems related to your E-mail service.

If you would like to change your E-mail address with MetLife, or if you would like a paper copy of the Documents, or if you believe that you have not received your Documents, please notify us immediately.

By signing this application, you understand and agree that if you wish to discontinue receiving Documents electronically it is your obligation to revoke this Authorization by another written document.

By signing this application also, you declare that you have read and understood MetLife's privacy policies and Terms of Use on www.metlife.com/about/privacy and you will review sany Terms of Use or Privacy Statement of any future service providers used by MetLife. You understand that although MetLife take every precaution to protect the privacy of members' information, MetLife cannot guarantee safety of your information. You consent to provide your E-mail address to be included in MetLife's E-mail list and accept any inherent risks involved with E-mail communications.

NEED HELP?

COUNTRY	UAE	Kuwait	Oman	Bahrain	Qatar	Any other Country
CALL US	800 - MetLife (800 - 6385433)	+965 2 247 4277	800 70708	800 08033	800 9711	+971 4 415 4555
MAIL US	P.O. Box 371916, Dubai – U.A.E.					
E-MAIL US	CustomerServices.Gulf@metlife.ae					

Full Name in his/her own handwriting	X Signature	D D M M Y Y Y Y
Beneficiary's Name	Beneficiary's Signature	Date
Full Name in his/her own handwriting	X Signature	D D M M Y Y Y Y
Witness Name	Witness Signature	Date