Accidents Dismemberment Claim Report

By furnishing this blank the Company makes no admission of liability or waiver of its rights. To be completed by injured person (if infant, by Parent or Guardian) and returned within 15 Days.

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

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

Please complete all relevant information Completely and Legibly.

CLAIMANT'S STATEMENT

1) **Full Name of Insured** ____ Date of Birth D D M M Y Y Y Y
Present Address ____ Policy No. ____

2) **(a) Give full description of injury and tell where, how and when did it happen?**

(b) Describe any disease or infirmity affecting injury

3) **(a) Exact date when injury occurred** D D M M Y Y Y Y
(b) Exact date injury resulted in loss of entire sight or severance of member D D M M Y Y Y Y

4) **Hospitals** (Give complete names, addresses, and dates of confinement)
Name ____ Address ____ From ____ To ____
Name ____ Address ____ From ____ To ____

5) **(a) Give names and addresses of all physicians who have treated you for this injury**
Name ____ Address ____
(b) Give name and address of usual family physician
Name ____ Address ____

6) **What other accident, sickness or disability insurance do you carry?** (Name companies, societies, etc., and describe benefits).
Name ____ Address ____
Benefits ____

7) **Present Occupation** ____ **Duties** ____
Name and Address of Employer
Name ____ Address ____

8) **What other medical or surgical treatment has been received during the past five years?** (Give dates, nature of illnesses, or injuries and names and addresses of attending physicians and names and addresses of clinics or hospitals where treated)

9) **What other organizations or companies have paid you indemnity for sickness or injury?**
Name ____ Address ____

I hereby authorize any hospital, physician or other who has attended me, or any employer, to furnish to the MetLife or its representatives, any and all information with respect to any sickness or injury, medical history, consultation prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a copy of this authorization shall be considered as effective and valid as the original.

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.

PHYSICIAN'S STATEMENT ON OTHER SIDE

Approved by:
Attending Physician ____ M.D.
Sign Your Full Name ____ Dated D D M M Y Y Y Y

MET/GCD/ADCR-CL20-APP-E/12-14
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ATTENDING PHYSICIAN'S STATEMENT

Patient's Name ____ Age ____

1. **Nature of Injury** (Describe complications if any) ____
2. **When did symptoms first appear or accident happen?** Date D D M M Y Y Y Y
3. **When did Patient first consult you for this condition?** Date D D M M Y Y Y Y
4. **(a) Has the Patient ever had the same or similar condition?** ☐ **Yes** ☐ **No**

   (b) If yes, state when and describe. ____
5. **(a) Is dismemberment or loss of sight due solely to injuries sustained in the accident?** ☐ **Yes** ☐ **No**

   (b) If no, describe any disease or infirmity affecting injury. ____
6. **Dismemberment**

   Describe actual place of severance. ____
7. **Loss of Sight**

   (a) Is loss of sight entire and irrecoverable? ☐ **Yes** ☐ **No**

   (b) If yes, give exact date it occurred, D D M M Y Y Y Y

   (c) If no, is it anticipated? ☐ **Yes** ☐ **No**

   (d) When? Approximate Date D D M M Y Y Y Y
8. **(a) Is a corneal transplant or other surgery or treatment contemplated to recover all or any part of this loss of sight?** ☐ **Yes** ☐ **No**

   (b) If yes, state when and explain fully. ____
9. **(a) Status of vision prior to injury.** Right Eye ____ / ____ Left Eye ____ / ____

   (b) Present status of vision. (If none, state none) Right Eye ____ / ____ Left Eye ____ / ____

   (c) Describe any disease of infirmity affecting sight prior to injury ____
10. **(a) Nature of surgical procedure, if any (describe fully).** ____

    (b) Date performed D D M M Y Y Y Y

    (c) Where was it performed? ____

    (d) If in Hospital ☐ In patient ☐ Out patient
11. **Give dates of treatment**. Office D D M M Y Y Y Y Home D D M M Y Y Y Y

    Hospital D D M M Y Y Y Y
12. **(a) Is the Patient still under your care for this condition?** ☐ **Yes** ☐ **No** **(b) If discharged, give date** D D M M Y Y Y Y
13. **If the Patient was hospitalized, give names and addresses of hospitals and dates of confinement**.

Hospital	Address	From	To

14. **Give names and addresses of all other attending physicians.**

Name	Address

15. **In condition due to injury arising out of the Patient's employment?** ☐ **Yes** ☐ **No**

Signature (Attending Physician) X ____ Date D D M M Y Y Y Y

Telephone Include Country & Area Code Street ____ Street Address ____

City / Town ____ State / Province ____ Zip Code ____

CLAIMANT'S STATEMENT ON OTHER SIDE