Recovery Benefit Plan

Claim Form

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

GULF OPERATIONS
P.O. Box 371916, Dubai, United Arab Emirates
www.metlife-gulf.com

Policy No.

PART A - INSURED'S STATEMENT

INSURED'S NAME

First Name | Middle Name | Last Name

INSURED'S ADDRESS

Country | City / Town | P.O. Box

Area / Street | Building | Flat / Villa No.

Telephone (Country Code – Area Code –) | Mobile (Country Code – Area Code –)

1. **Nature of disease**
2. **Date of first consultation**
3. **Date of diagnosis of disease**
4. **Has the disease been caused by**
   a. Acquired Immune Deficiency (AIDS)?
   b. Misuse of drugs or alcohol?
5. **a. Name of treating physician**
   b. Physician's address
   c. Telephone No.

AUTHORIZATION

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of their records) regarding myself, my medical history in general and this claim in particular to American Life Insurance Company (MetLife).

A photocopy of this authorization shall be considered as 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."*

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.

Signature of Insured (x Signature) | Date (D D M M Y Y Y Y)

PART B - PHYSICIAN'S STATEMENT

INSURED'S NAME

Patient's Name | Middle Name | Last Name

Height | Weight

HISTORY OF RISK FACTORS:

A. Hypertension ☐ Yes ☐ No

If yes , exact date of onset

HTN Question should be completed by the Doctor who diagnosed this condition first.

B. Diabetes Mellitus ☐ Yes ☐ No

If yes , exact date of onset

DM Question should be completed by the Doctor who diagnosed this condition first

C. Dyslipidemia ☐ Yes ☐ No

If yes , exact date of onset

D. History of smoking ☐ Yes ☐ No

If yes , no of cigarettes smoked per day and since when

E. Ischeamic Heart Disease ☐ Yes ☐ No

If yes , exact date of onset

1. Complete for Myocardial Infarction

a. Final diagnosis

b. Date of diagnosis D D M M Y Y Y Y

c. Was there history of chest pain? ☐ Yes ☐ No

If yes, please give details.

d. Did EKG reveal new Electrocardiographic changes? ☐ Yes ☐ No

If yes, please give details.

e. Was there elevation of Cardiac Enzymes? ☐ Yes ☐ No

(Company requires all laboratory tests, EKGS and X-RAYS done)

2. Complete for Coronary Artery Disease requiring surgery

a. Date of diagnosis D D M M Y Y Y Y

b. Nature of surgery

c. Date of surgery D D M M Y Y Y Y

d. No. of coronary arteries involved

(Company requires all Laboratory Tests, EKGs and Catheterization Film & Diagram)

3. Complete for Cerebral Stroke

a. Final diagnosis

b. Date of diagnosis D D M M Y Y Y Y

c. Did EEG reveal permanent neurological deficit?

(Company requires all Laboratory Tests, EEGs and Neurologist Opinion Confirming diagnosis)

4. Complete for Cancer

a. Detailed final diagnosis including location

b. Date of diagnosis D D M M Y Y Y Y

c. Medical history

(Company requires all Laboratory Tissue Biopsy Pathology Tests)

Name of Attending Physician

Signature of Physician x Signature Date D D M M Y Y Y Y

5. Complete for Chronic, Irreversible Renal Failure

a. Detail diagnosis

b. Date of diagnosis D D M M Y Y Y Y

c. Medical history

d. Nature of Treatment

(Company requires all Laboratory Tests)

6. Complete for Blindness caused by sickness

a. Nature of sickness

b. Is blindness total, permanent and irrevocable? ☐ Yes ☐ No

c. Date of diagnosis D D M M Y Y Y Y

d. Medical history

7. Complete for diagnosed disease

1. Date you were first consulted for the symptoms of this condition:

   Month Day: Year:

2. Date patient had previous medical attention for this condition:

   Month Day: Year:

   Physician

   Address / Street City

3. Dates confined to Hospital:

   From To

   From To

4. Hospital Name

   Address

5. Has the disease been caused by

   a. Acquired Immune Deficiency Disease virus (HIV), or is it an AIDS related complex of infection by HIV Virus? ☐ Yes ☐ No

   b. Misuse of Drugs or Alcohol? ☐ Yes ☐ No

Name of Attending Physician

Hospital or Clinic Address

Telephone No.

Signature of Physician X Signature Date D D M M Y Y Y Y