

# Total Disability Benefits

## Claimant's Statement



### Gulf Operations

P.O. Box 371916, Dubai, UAE - Tel. 04 415 4555, Fax 04 415 4445

This statement must be fully answered by the Insured or his duly appointed Guardian or Committee, If insane If, due to physical condition, Insured in unable to answer there questions beneficiary or nearest relative may do so.

▶ Please provide all relevant information completely and legibly.

1. Full name of the Insured

2. Occupation  Daily Duties

3. (a) Insured's date of birth         (b) Place of birth

4. Height  Weight

5. Describe fully the Insured's present condition

6. To what extent is the Insured unable to follow any occupation?

7. Give date of injury or beginning of illness causing present condition

8. When was the Insured compelled to give up part of his duties

9. When was the Insured compelled to give up all of his duties? (Give exact date)

10. How does the Insured spend his time?

11. Has Insured done any kind of work since commencement of disability? If so, give particulars

12. When does the Insured expect to return to work?

13. Give name and address of every physician or practitioner who attended or prescribed for the Insured during present affliction

a. Duration				b. Name of Physician or Practitioner				c. Address			
From			20	to			20				
From			20	to			20				
From			20	to			20				

14. For what disease, injury, ailment or affliction has the Insured required the services of a physician or practitioner prior to present affliction?

a. Name of injury, diseases, etc.	b. Duration				c. Name of Physician or Practitioner				d. Address			
	From			20	to			20				
	From			20	to			20				
	From			20	to			20				

15. Has either of Insured's parents or any of his brothers or sisters or other relative been afflicted with a similar disease? ....  Yes  No  
If so, give particulars

16. Is the Insured's estate represented by a Committee or Guardian? (If so, furnish copy of appointment) .....  Yes  No

17. What other life, government, health or accident insurance providing for disability benefits to the Insured?

a. Duration	b. Name				c. Address			

**Declarations**

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated, or in now treating me, to impart to MetLife any information it my desire.

"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."

Full name of the Insured  Signature of Insured

Signed at     20

City Country Day Month Year

### Need help?

Country	UAE	Kuwait	Oman	Bahrain	Qatar	Any other Country
Call us	800 - MetLife (800 - 6385433)	+965 2 208 9333	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.com					