Credit Life Claims

Claim Form

Gulf Operations
P.O. Box 371916, Dubai, UAE
Tel: +971 4 415 4555 - Fax: +971 4 415 4445

I wish to claim for following benefit (please tick the appropriate benefit claiming for):

☐ Involuntary Loss of Employment (ILOE) ☐ Permanent & Total Disability (PTD) ☐ Death
☐ Critical Illness ☐ Hospitalization

Applicant's Details:

First Name | Middle Name | Last Name

Date of Birth (D D M M Y Y Y Y) | Passport No.

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.

Applicant's Contact No. (Local) Country Code – Area Code –

Applicant's Contact No. (Home Country) Country Code – Area Code –

E-mail

Benefits:

I. Involuntary Loss of Employment (ILOE)

Please attach the following documents: (1) Letter of Termination; (2) Bank account details (please complete form); (3) Visa copy (valid or cancellation copy with date); (4) Copy of EID and passport copy..

Last working day

Employer's Name

Employer's Contact No. Country Code – Area Code –

II. Death

Please attach the following documents: (1) Death certificate; (2) Medical report showing cause of death; (3) Succession certificate issued by the Court / IDs; (4) Detailed medical report with exact date of onset of disease causing death (for claims where pre ex applies); (5) Copies of IDs of insured and legal heirs.

Date of Death (D D M M Y Y Y Y) | Cause of Death

Claimant's Name

Claimant's Contact No. (Local) Country Code – Area Code –

Claimant's Contact No. (Home Country) Country Code – Area Code –

Claimant's E-mail

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III. Critical Illness

Please attach the following documents: (1) Medical report stating all previous medical history and exact date of onset of disease, other risk factors and other required lab test reports

Date of Diagnosis D D M M Y Y Y Y Name of critical illness diagnosed

IV. Hospitalization

Please attach the following documents: (1) discharge summary showlng dates of admission and discharge along with nature of ailment, date of onset, service performed and treatment plan; (2) copy of ID.

Date of incident D D M M Y Y Y Y Cause of Hospitalization

V. Permanent & Total Disability (PTD)

Please attach the following documents: (1) Medical report stating all previous medical history and exact date of onset of disease causing PTD, current status and other risk factors

Date of incident D D M M Y Y Y Y Cause of PTD

Account Details of Customer for ILOE/HOSPITALIZATION/CI/PTD Benefit:

First Name Middle Name Last Name

Bank's Name:

Account No. / IBAN No.

SWIFT:

IFSC (mandatory for Banks in India)

I declare that the information provided above is true & correct and understand that wrong information may render my claim void and recoverable from me.

MetLife reserves the right to ask for further documentation if and when required for proper adjudication of the claim.

Signatures:

Signed at City Country D D M M Day Month 20 Y Y Year

Full Name Full Name in his / her own handwriting Signature X

American Life Insurance Company is a MetLife, Inc. Company

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Need help?

How to contact us How to submit the form						
Country	**UAE**	**Kuwait**	**Oman**	**Bahrain**	**Qatar**	**Any other Country**
Call us	800 - MetLife (800 - 638 5433)	+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.ae gulflifeclaims@metlife.com					
Website	www.metlife-gulf.com					

How to submit the form

Please send **original** documents to:

American Life Insurance Company (MetLife) – Customer Service

New Century City Tower,
4th floor, Plot 129 -187
Port Saeed,
Deira, Dubai.

Declaration:

I hereby provide MetLife my unambiguous consent to process, share, and transfer my personal data to a recipient outside the country (e.g. to the Company Headquarters in th e USA and / or to other branches or affiliates of the Insurer's Group and Reinsurer) where the transfer, sharing, is necessary for the performance of the contract or for the compliance with any legal obligation to which the Company is subject and where necessary transfer, share any such information with the regulators and other law enforcement agencies for the performance of its obligations related to the international sanctions and other regulations applicable to the Company

Data Transfer: I hereby provide MetLife my unambiguous consent, to process, share, and transfer my Personal Data to any recipient whether inside or outside the country, including but not limited to MetLife Headquarters in the USA, its branches, affiliates, reinsurers, business partners, professional advisers, insurance brokers and/or service providers where MetLife believes that the transfer or share, of such Personal Data is necessary for: (i) the performance of this Policy; (ii) assisting MetLife in the development of its business and products; (iii) improving MetLife customers experience; (iv) for the compliance with the applicable laws and regulations; or (v) for the compliance with other law enforcement agencies for international sanctions and other regulations applicable to MetLife. MetLife will ensure that such recipients will have sufficient confidentiality obligations to procure the confidentiality of the personal information and provided that the Company complies with applicable laws in respect of such processing, sharing and transferring of that Personal Data. For clarity, Personal Data means any data/information related to Insured and/or Insured's family which might include any health, identity and financial information or contact details, disclosed to MetLife at any time.

I understand that Coverage and / or Payment under the insurance contract will NOT be made if: (i) the policyholder, insured, or person entitled to receive such payment is residing in a sanctioned country; or (ii) the policyholder, the insured, or person entitled to receive such payment is listed on the Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) list, the OFAC Sectorial Sanctions Identifications list or any international or local sanctions list; or (iii) the payment is claimed for services received in any sanctioned country. I also understand that the Company shall not be liable to pay any claim or provide any coverage or Benefit to the extent that the provision of such coverage or Benefit would expose the Company to any sanction under any applicable laws.

Electronic Communication:

1- Notifications: I hereby authorize MetLife to send me notifications and notices electronically (including but not limited to short message services "SMS", emails and any other electronic means or methods of communications ("Notifications"). I accept receiving Notifications and understand that MetLife makes no warranty that the Notifications 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 Notifications error or interruption or for any reason related to receiving / not receiving the Notifications. MetLife is not responsible for non-receipt of Notifications due to invalidity of the addresses or other technical problems.

2- Sending and receiving the documents electronically: By providing my e-mail address and signing this application I agree to receive from MetLife the policy document, certificate and / or any other documents and to send to MetLife all types of documents and information related to the policy ("Documents") via electronic mail ("E-mail"). I am fully aware that having chosen this electronic means of sending or receiving information & Documents, it is my responsibility to ensure that the E-mail address I have provided in this application is correct at all times, and that it's my responsibility to inform MetLife immediately should my E-mail address change or should I cease to receive the Documents. I agree that all information & Documents sent to or received from my E-mail address as stated in this application will be considered valid and originated from me or sent to me personally. MetLife is not responsible for non-receipt of E-mails due to invalid E-mail addresses or other technical problems related to my E-mail service.

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I acknowledge that if I opt to change my E-mail address with MetLife, or if I would like to receive a paper copy of the Documents, or if I believe that I have not received my Documents, I will notify MetLife immediately.

By signing this application, I understand and agree that if I wish to discontinue receiving Documents electronically it is my obligation to revoke this authorization by another written document. By signing this application also, I declare that I have read and understood MetLife's privacy policies and Terms of Use on www.metlife-gulf.com/en/privacy-policy and I will review any Terms of Use or Privacy Statement of any future service providers used by MetLife.

I understand that although MetLife take every precaution to protect the privacy of member's information, MetLife cannot guarantee safety of my information.

I consent to provide my E-mail address to be included in MetLife's E-mail list and accept any inherent risks involved with E-mail communications.

Disclaimer content:

I hereby confirm that the documentation submitted including this form are true and unaltered and I have all the original documents that can be presented upon request of the insurance company at any time during the process period of this claim and up to one year following the claim decision. I hereby confirm to process payment in my favor if and when MetLife approves and decides to accept the claim for payment and consider this document as Receipt & Discharge.

Authorization:

I, Full name of Claimant/Beneficiary give my permission to release information concerning Full name of Insured 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 database 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.

Signatures

Date D D M M 20 Y Y
Day Month Year

Claimant's signature X

*******FORM MUST BE COMPLETED, DATED & SIGNED TO BE VALID*******

Insured's signature Signature
X