Medical Claim Reimbursement Form

Complete the form in CAPITAL LETTERS.

FASTER SECURE RECOMMENDED HASSLE-FREE	submitting	E and GET your mor your claims on e-Se eservicesgulf.metlife.con	ervices and selecti	<mark>ng wire t</mark> r	CONTRACTOR STATES			
Instructions: Use this f	orm to make clai	m for in-patient or out-patient	atient treatments.					
		ng of your claim, please ensure th						
-		should be submitted either in E	English or Arabic. Documer	nts in other lang	guages must be	e translated	by an official public	: translator
2. All neces	, ,	documents are to be submitted	5	rred date. Subj	ect to your pol	licy terms ar	nd conditions, MetLi	ife reserves
5		you submit after 90 days of the		com/icoc)				
2- Atte	nding Physician S	ursement Form (if not sub Section (mandatory) ts - Please refer to the che	-	-services)				
EMPLOYEE'S SECTION	(*All Fields are M	landatory) – Not required	l if submitting the clai	m directly or	n e-Services			
Employees's Full Name*					Date of Bir	th D D		YY
]			
Patient's Full Name*					Date of Bir	th D D		YY
Employee's Nationality*			Patient's Nat	tionality*				
Employee Contact No.*	Country Code – A	rea Code 🚽						
Policy Number* (Mentioned on your Medical Card)			Certificate N (Mentioned on your					
Employee E-mail Address.*								
Address*								
REIMBURSEMENT MET	THOD							
Wire Transfer ¹			Cheque					
¹ Bank detail must be upda	ted on e-services							
Total Amount Claimed	i [C	Currency		
AUTHORIZATION STAT								
or any other company, in:	stitution or any other per ncluding copies of their r	ocuments submitted with the claim f rson who has any record or informati records with reference to my sickness	ion about me and / or any of m	y family members	to provide MetLi	fe (American	Life Insurance Company	y) with the
DISCLAIMER								
	ce has been terminated. I	eimbursements to the account indicate If ever MetLife credits more money the overpayment.						
		eimbursement levied by the remitting , if any, with your banking provider".		e levied by the ber	neficiary's bank /	other third-pa	arty provider will be bo	rne by the
• I verify that the documer recognize that at the sole	ntation submitted electro discretion of the MetLife 80 days from the request	onically is true and unaltered and I have e, these documents may be requested t. Failing to comply could imply the cl	ave all the original documents t d at any time during a period o	f one year countee	d from the submi	ission of the c	laim, which I will provid	le within a
OFAC's sanctions list, in individuals who: i) are	ncluding but not limite residing in a sanctione	rse for treatment obtained in, rei ed to payments to any financial i d country; ii) are listed on the OFA s of receiving medical, or other tre	nstitutions or medical provid AC Specially Designated National States (Specially Designated National States)	ders located in a onals (SDN) list o	sanctioned cou or any other inte	untry. Also, Mernational or	NetLife will not pay a local sanctions list; o	a claim to r iii) have
branches or affiliates of t	 traveled to a sanctioned country for purposes of receiving medical, or other treatment or services, subject to the Policy and / or Supplementary contract terms and conditions. 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 the 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 						which the	

MET/MND/IMC-APP-E/10-15 ® MetLife

MetLi

CustomerServices.Gulf@metlife.ae

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GULF OPERATIONS

www.metlife-gulf.com

Employee's Signature						Date	D
③ Need Help?	UAE 800 6385433	KUWAIT +965 220 89333	OMAN 800 70708	BAHRAIN 800 08033	QATAR 800 9711	ANY OTHER COUNTRY +971 4 415 4555	

sanctions and other regulations applicable to the Company.

MetLife

Medical Claim Reimbursement Form

ATTENDING PHYSIC To be filled by attendin	CIAN SECTION (*Mandatory Fields) ng physician	
Patient's Full Name	Da	ate of Birth
Chief Complains*		
Diagnosis*		
How long has the patient	t been suffering from this sickness?*	
Please specify the date sy	mptoms first appeared.	
If treated by other medica	al provider please specify the name and treatment details	
If the claim is resulting fro	om pregnancy / childbirth, please provide the LMP*	
Details of the treatment ((other than Prescription)	
If further treatment or op	perative procedure anticipated, please provide the details	
Physician's Name, Addres	ss and Tel. No.	
Physician's Signature and	i stamp	

CHECKLIST FOR INSURED MEMBER

REQUIRED	СНЕСК ВОХ	DOCUMENTS	NOTES
YES		Claim Form (including Attending Physician Section)	Fully completed and signed by you and your physician / surgeon
YES		Detailed medical report	Detailing ailment / diagnosis or accident with dates it started / happened, signed by your treating physician
YES		Original hospital / clinic bill	Original
If applicable		Copy of all relevant X-Rays / Echography / MRIs and reports	Should reflect your name and date they were taken
If applicable		Copy of all lab tests and reports	Only related to this incident
If applicable		Copy of police report	Required if claim relates to an accident

Please remember:

To help us process your insurance claim as quickly as possible, we ask you to provide the above documents. Otherwise your claim could be delayed or potentially rejected.

HOW TO SUBMIT THE CLAIM

Login to e-Services OR Please contact your H.R. for the Claim Submission Process