Addition of Recovery Benefit Plan
Request Form

GULF OPERATIONS
P.O. Box 371916, Dubai, United Arab Emirates
Tel +971 4 415 4555 Fax + 971 4 415 4445

INSTRUCTIONS: Use this form to add the Recovery Benefit Plan. Please complete this form in its entirety to avoid any delays in processing. If you need any assistance in completing this form, please contact our customer service representatives.

REQUIREMENTS: (1) Additional of a Recovery Benefit Plan Form; (2) Valid Passport Copy or Copy of Valid I.D.; (3) Valid Visa Copy (if Applicable);

POLICY DETAILS

Policy No.

POLICY OWNER'S DETAILS

First Name | Middle Name | Last Name

I.D. Type | I.D. No. | Expiry Date

Gender ☐ Male ☐ Female | Age Last Birthday | Date of Birth D D M M Y Y Y Y | Place of Birth

Mobile No. Country Code – Area Code – | E-mail

Address Line 1 | P.O. Box | City

Address Line 2 | Country

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.*

1. Please answer to the best of your knowledge or belief

a) When did you last consult a physician?

b) Please state reason for consultation:

c) What treatment was given or medication prescribed?

d) Please state name and address of physician:

2. Have you ever been treated for or ever had any known indication of:

Note: If the answer to any question is "Yes", please include diagnoses, dates, duration, degree of recovery or results and names and addresses of all attending physicians and medical facilities.

		Yes	No	
a)	Disease or disorder of eyes, ears, nose or throat?	☐	☐	
b)	Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke; mental or nervous disease or disorder?	☐	☐	
c)	Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory or lung disease?	☐	☐	
d)	Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease of the heart or blood vessels?	☐	☐	
e)	Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disease of the stomach, intestines, liver or gallbladder?	☐	☐	
f)	Sugar, albumin, blood or pus in urine, venereal disease, stone or other disease of kidney, bladder, prostate or reproductive organs?	☐	☐	
g)	Diabetes, thyroid or other endocrine disease?	☐	☐	
h)	Neuritis, sciatica, rheumatism, arthritis, gout, disease or disorder of the muscles or bones, including the spine, back or joints?	☐	☐	

Insured's Signature X Signature

Policy Owner's Signature X Signature

	Yes	No	
j) Deformity, lameness or amputation?	☐	☐	
j) Disease of skin, lymph glands, cyst, tumor or cancer?	☐	☐	
k) Allergies; anemia or other disease of the blood?	☐	☐	
3. Are you now under observation or taking treatment or medication for any disease or disorder?	☐	☐	
4. Have you had any change in weight in the past year?	☐	☐	
5. Have you within the past 5 years:			
a) Had any mental or physical disease or disorder not listed above?	☐	☐	
b) Had a check-up, consultation, illness, injury or surgery?	☐	☐	
c) Been a Patient in a Hospital, clinic, sanatorium or other medical facility?	☐	☐	
d) Had electrocardiogram, X-ray, other diagnostic test?	☐	☐	
e) Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐	
6. Do you intend to seek medical advice, treatment, or have any medical tests performed?	☐	☐	
7. AIDS (Acquired Immune Deficiency Syndrome) Describe in detail any affirmative answers:			
i) Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease	☐	☐	
ii) Have you been told you had AIDS or AIDS Related Complex?	☐	☐	
iii) Have you had or been told you had a positive blood test for antibodies to the AIDS virus (Human Immunodeficiency Virus)?	☐	☐	
iv) Do you have any of the following which are unexplained: Fatigue, weight loss, diarrhea, enlarged lymph nodes, or unusual skin lesions?	☐	☐	
8. Please state current consumption of			
Tobacco ☐ per day/week	☐	☐	
Alcohol ☐ per day/week	☐	☐	
If you do not smoke cigarettes now but did so previously, when did you stop?			
9. Family history: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide?	☐	☐	

	Age if Living?	State of Health / Cause of Death?	Age at diagnosis	Age at Death
Father				
Mother				
Brothers and Sisters				
No. of Living ☐				
No. of Dead ☐				

10. For Females Only

	Yes	No
a) Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	☐	☐
b) Are you now pregnant? (If yes, how many months) ☐	☐	☐

11. a) Your present weight ☐ lbs. or ☐ kg.

b) Your present height ☐ ft. ☐ in. or ☐ cm.

Insured's Signature X Signature

Policy Owner's Signature X Signature

DECLARATIONS

(a) I declare that I am the person named as the Proposed Insured and that the above statements and answers are true and complete to the best of my knowledge and belief. I confirm that they are correctly recorded and are a continuation of and form a part of the application on my life to American Life Insurance Company (MetLife).

(b) 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.

(c) 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".

(d) I hereby authorize MetLife to send me notifications and notices via short message service "SMS" and I accept receiving SMS and understand that MetLife makes no warranty that the SMS 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 SMS error or interruption or for any reason related to receiving / not receiving SMS.

U.S.A. INTERNAL REVENUE SERVICE (IRS) DECLARATION:

In submitting and in signing this form, the applicant(s) certify(ies) that the Insured, Joint Insured, Applicant, and any designated Beneficiary(ies): (select the answer that applies)

☐ **ARE** ☐ **ARE NOT** United States persons for United States (U.S.) Federal Income Tax purposes [1][2]

The Applicant(s) agree(s) to inform the Company within thirty (30) days of the Applicant(s) knowledge of such change if the Applicant(s) or any designated Beneficiary become(s) a U.S. person of U.S. Federal Income Tax purposes or if the Applicant(s) assign(s) the policy to such a U.S. person.

Please note that a false statement or misrepresentation of tax status by a U.S. person could lead to penalties under U.S. law.
If you are a United States person, fill in the details below:

- **U.S. Tax ID number of Applicant(s) & Insured:**
- **U.S. Tax ID number of Beneficiary(ies):**

1. This question is for U.S. Federal Income Tax purposes. The U.S. Internal Revenue Service requires the Company to report the taxable income paid to persons subject to United States Federal Income Tax. PLEASE NOTE that if you are a U.S. person for U.S. tax purposes and fail to provide a U.S. Tax Identification Number to the Company, the IRS requires the Company to withhold tax from taxable income payments made to you at the rate of up to 31%.
2. For purposes of this declaration a U.S. person is a citizen or resident of the United States, a United States partnership, and trust which is controlled by one or more U.S. persons and is subject to the supervision of a U.S. court.

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) DECLARATION:

The Insured / Owner consents to MetLife, its officers and agents disclosing any Confidential Information to:

(i) Any group member and representatives of MetLife in any jurisdiction (together with MetLife, the "Permitted Parties");

(ii) Any persons as required by any law (including but not limited to the U.S.A. Foreign Account Tax Compliance Act) or authority (including but not limited to the U.S.A. Internal Revenue Service) with jurisdiction over any of the Permitted Parties;

(iii) Professional advisers, insurer, reinsurer or insurance broker and service providers of the Permitted Parties who are under a duty of confidentiality to the Permitted Parties;

(iv) Any actual or potential assignee, novatee or transferee in relation to any of MetLife's rights and / or obligations under this Policy (or any agent or adviser of any of the foregoing); and

"Confidential Information" means all information relating to the Insured / Owner (whether marked "confidential" or not) disclosed by whatever means either directly or indirectly to MetLife which concerns the business, operations or customers of the Insured / Owner (including but not limited to contact details, tax identification number / social security number, account balances / activities or any transactions undertaken with MetLife)."

MetLife will deduct any withholding required by the US Foreign Account Tax Compliance Act ("FATCA").

MetLife reserves the right, within its sole discretion, to terminate the Policy in the event that appropriate documentation of Insured's / Owner's US or non-US status for purposes of FATCA is not timely provided to MetLife. In particular, in the event that applicable local laws or regulations would prohibit withholding on payments to the account or prohibit the reporting of the account, and no waiver of such local law is obtained, MetLife reserves the right to close the account.

Insured's Signature X Signature

Policy Owner's Signature X Signature

E-mail Declaration:

By providing your E-mail address and signing this application you agree to receive the policy document, certificate and / or any other documents ["Documents"] via electronic mail ["E-mail"]. Please be aware that having chosen this electronic delivery of Documents, it is your responsibility to ensure that the E-mail address you have provided us is correct at all times.

MetLife is not responsible for non-receipt of E-mails due to invalid E-mail addresses or other technical problems related to your E-mail service.

If you would like to change your E-mail address with MetLife, or if you would like a paper copy of the Documents, or if you believe that you have not received your Documents, please notify us immediately.

By signing this application, you understand and agree that if you wish to discontinue receiving Documents electronically it is your obligation to revoke this Authorization by another written document.

By signing this application also, you declare that you have read and understood MetLife's privacy policies and Terms of Use on www.metlife.com/about/privacy and you will review any Terms of Use or Privacy Statement of any future service providers used by MetLife. You understand that although MetLife take every precaution to protect the privacy of members' information, MetLife cannot guarantee safety of your information. You consent to provide your E-mail address to be included in MetLife's E-mail list and accept any inherent risks involved with E-mail communications.

SIGNATURES

Signed at _____ (City) _____ (Country) D D M M 20 Y Y (Day / Month / Year)

Full Name of Proposed Insured	Full Name in his/her own handwriting	Signature	X
Full Name of Policy Owner	Full Name in his/her own handwriting	Signature	X
Full Name of Witness / Agent	Full Name in his/her own handwriting	Signature	X
Agent Code			

NEED HELP?

HOW TO CONTACT US						
COUNTRY	UAE	Kuwait	Oman	Bahrain	Qatar	Any other Country
CALL US	800 - MetLife (800 - 6385433)	+965 220 89333	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					
WEBSITE	www.metlife-gulf.com					

HOW TO SUBMIT THE FORM

Please send **original** documents to:

Customer Care - MetLife
P.O. Box 371916
Dubai – U.A.E.

American Life Insurance Company is a MetLife, Inc. Company