Policy Change/Reinstatement Personal Accident
Request Form

Policy No. _____

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 request for changes or reinstatement of your individual Accident & Health policy. If you need any assistance in completing this form, please contact our customer service representatives.

REQUIREMENTS: (1) Policy Change / Reinstatement form; (2a) Valid Passport copy or Copy of Valid I.D. and Valid Residency copy (if applicable) in case of "CHANGE OF BENEFICIARY" or "CHANGE OF OWNERSHIP" (2b) Supporting documents in case of "CHANGE OF NAME"

SECTION A

	Full Name of Insured / Owner / Spouse / Child	Nationality	Residency	Relationship to Policy Owner	Client's ID	Date of Birth	Height	Weight	Current Residence	
									City	Country
1										
2										
3										
4										
5										

	Full Name of Insured / Owner / Spouse	Employer's Name	Nature of Business	Occupation	Daily Duties	Income Amount
1						
2						
3						
4						
5						

Correspondence

Country _____ City / Town _____ P.O. Box _____

Area / Street _____ Building _____ Flat / Villa No. _____

Telephone Country Code – Area Code – _____ E-mail _____

Do you intend to travel during the next twelve months? ☐ **Yes** ☐ **No** If 'Yes', please provide the travel details.

Full Name of Traveler	Destination - City/Country	Purpose	Duration

Insured's Signature X Signature

Policy Owner's Signature X Signature

SECTION B

☐ **Change of Beneficiary**

Full Name of New Beneficiary	Relationship	Address	Date of Birth	Nationality	Residency	Percentage
			D D M M Y Y Y Y			
			D D M M Y Y Y Y			
			D D M M Y Y Y Y			
			D D M M Y Y Y Y			
			D D M M Y Y Y Y			

☐ **Change Mode of Payment from** _____ to _____ as of premium due _____

☐ **Change of Occupation to** _____

Old Signature X _____ New Signature X _____

☐ **Additional Request** _____

SECTION C

☐ **Schedule of Benefits New Requested (include all benefits, even those not to be changed)**

Currency	**Insured** Occupational Class		**Spouse** Occupational Class		**Dependent(s)**	
Benefits	**Amount**	**Premium**	**Amount**	**Premium**	**Amount**	**Premium**
Accidental Death, Dismemberment, and Permanent Total Disability	Principal Sum		Principal Sum		Principal Sum	
Accident Medical Expense Reimbursement	Amount		Amount		Amount	
Accident Disability Income 104 weeks	Weekly Benefit		Weekly Benefit		**Not Offered**	
Accident & Sickness In-Hospital Income (67E)	Weekly Benefit		Weekly Benefit		Weekly Benefit	
In-Hospital Income 50% extra for Heart and Cancer	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**		**Not Offered**	
In-Hospital Double Income in USA, Canada, Europe	☐ **Yes** ☐ **No**		☐ **Yes** ☐ **No**			
Accident & Sickness In-Hospital Surgical Expense (77D)	Maximum Benefit		Maximum Benefit		Maximum Benefit	
Other Benefits						

Please state your average weekly income over the past 12 months: _____

☐ **Reinstatement:** I hereby apply for Reinstatement of the above Policy.

I have paid _____ with this request

Declaration below pertains to all Named Insureds:

☐ In case of a female applicant, further state that I am not now pregnant.

- I certify that there has been no change in my condition of health, and that I received no medical attention, consultation or examination whatsoever, nor have I done any medical tests, including blood tests for antibodies to the AIDS Virus (Acquired Immunodeficiency Syndrome), since the date of completion of my application for insurance in American Life Insurance Company (MetLife); further, that all my answers as written in said application, including those relating to my occupation are still true (Except as noted below*).

  ***Note:** Notwithstanding anything to the contrary in the insurance policy or in the Supplementary Contracts attached thereto, the Company may rely solely upon this request to effect change without need to any endorsement whatsoever.*

Insured's Signature X Signature Policy Owner's Signature X Signature

DECLARATIONS

(a) I understand that the reinstatement of my policy is conditioned on the truth of this statement. I further declare that if the policy is reinstated, I fully understand and agree that it shall cover loss occurring after the date of such reinstatement and subject to the terms of the policy.

(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 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			

(To be completed by the Company)

The above Change / Reinstatement has been accepted by the Company and shall take affect as of _____

Date D D M M Y Y Y Y

Authorised Signature X

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