

Dismemberment Claim Report

CL-20 Partial Disability Form



By furnishing this blank the Company makes no admission of liability or waiver of its rights.
To be completed by injured person (if infant, by parent or guardian) and returned within 15 days.

American Life Insurance Company (MetLife)
Bahrain, Airport Road, P.O. Box 20281
Manama - Kingdom of Bahrain
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▶ Please provide all relevant information completely and legibly.

Claimant's statement

1) Full name of Insured Date of birth

Current address Policy no.

2) (a) Give full description of injury and tell where, how and when did it happen?

(b) Give full description of injury/sickness and tell where, how and when did it happen?

3) Hospitals (Give complete names, addresses, and dates of confinement)

Name Address From To

Name Address From To

4) (a) Give names and addresses of all physicians who have treated you for this injury

Name Address

(b) Give name and address of usual family physician

Name Address

5) What other accident, sickness or disability insurance do you carry? (Name companies, societies, etc., and describe benefits).

Name Address

Benefits

6) What other medical or surgical treatment has been received during the past five years? (Give dates, nature of illnesses, or injuries and names and addresses of attending physicians and names and addresses of clinics or hospitals where treated)

Approved by:

Attending physician M.D.

Sign your full name Dated

Physician's statement on other side

Bank details of Beneficiary / Payee required for wire transfer

Beneficiary / Payee Name

Beneficiary / Payee Full Address

Mobile No. - - E-mail

Bank Name Currency Account

Bank Address

Bank Account Holder Name

Bank Account No. Swift Code

IBAN No.

I, the undersigned, hereby confirm that all above information is correct and related to my Bank Account.

Signature

I hereby authorize any hospital, physician or other who has attended me, or any employer, to furnish to the MetLife or its representatives, any and all information with respect to any sickness or injury, medical history, consultation prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers. I agree that a copy of this authorization shall be considered as effective and valid as the original.

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.

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.

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 - 6385433)	+965 2 208 9333	800 70708	800 08033	800 9711	+971 4 415 4555	Please send original documents to: Customer Care - MetLife Bahrain, Airport Road P.O. Box 20281 Manama - Kingdom of Bahrain T. +973 1755 6608 F. +973 1731 1229
Mail us	P.O. Box 20281, Manama 319, Kingdom of Bahrain						
E-mail us	Gulfifeclaims@metlife.com						
Website	www.metlife-gulf.com						

We are committed to providing you with the highest service standards. If you feel that we have not lived up to these standards we would like to hear about it, so we can put it right for you. Please visit our "Feedback and complaints" page on www.metlife-gulf.com to see how you can get in touch and learn about our Complaints Handling Process.

American Life Insurance Company (MetLife) is licensed and regulated by the Central Bank of Bahrain as an insurance company (overseas insurance licensee - conventional insurance business), with a common capital stock of USD 40,000,000.

American Life Insurance Company is a MetLife, Inc. Company

Attending Physician's Statement

Patient's name Age

1. **Nature of injury** (Describe complications if any)

2. **When did symptoms first appear or accident happen?** Date

3. **When did patient first consult you for this condition?** Date

4. (a) **Has the patient ever had the same or similar condition?** Yes No

(b) **If 'ye's, state when and describe**

5. (a) **Is dismemberment or loss of sight due solely to injuries sustained in the accident?** Yes No

(b) **If 'no', describe any disease or infirmity affecting injury**

6. **Dismemberment**

Describe actual place of severance

7. **Loss of sight**

(a) **Is loss of sight entire and irrecoverable?** Yes No (b) **If 'yes', give exact date it occurred**

(c) **If 'no', is it anticipated?** Yes No (d) **When?** Approximate date

8. (a) **Is a corneal transplant or other surgery or treatment contemplated to recover all or any part of this loss of sight?** Yes No

(b) **If 'ye's, state when and explain fully**

9. (a) **Status of vision prior to injury** Right eye / Left Eye /

(b) **Present status of vision. (If none, state none)** Right eye / Left Eye /

(c) **Describe any disease of infirmity affecting sight prior to injury**

10. (a) **Nature of surgical procedure, if any (describe fully)**

(b) **Date performed**

(c) **Where was it performed?**

(d) **If in hospital** In patient Out patient

11. **Give dates of treatment.** Office Home

Hospital

12. (a) **Is the patient still under your care for this condition?** Yes No (b) **If discharged, give date**

13. **If the patient was hospitalized, give names and addresses of hospitals and dates of confinement**

Hospital	Address	From	To

14. **Give names and addresses of all other attending physicians**

Name	Address

15. **In condition due to injury arising out of the patient's employment?** Yes No

Signature (attending physician) Date

Telephone Include country and area code Street Street address

City/Town State/Province Zip code

Claimant's statement on other side