

# Recovery Benefit Plan

## Claim Form



▶ Please provide all relevant information completely and legibly.

[www.metlife-gulf.com](http://www.metlife-gulf.com)

American Life Insurance Company (MetLife)

Oman, P.O.Box 894, Postal Code 114, Jibroo, Sultanate of Oman

T. +968 2 478 7531, F. +968 2 470 04634, [Gulfifileclaims@metlife.com](mailto:Gulfifileclaims@metlife.com)

Policy No.

Certificate No.

### Part A - Insured's Statement

#### Insured's Name

First Name  Middle Name  Last Name

#### Insured's Address

Country  City / Town  P.O. Box

Telephone  -  -  Mobile  -  -

1. Nature of disease

2. Date of first consultation

3. Date of diagnosis of disease

#### 4. Payment method: Wire Transfer

##### 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

#### Authorization

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of their records) regarding myself, my medical history in general and this claim in particular to American Life Insurance Company (MetLife). I agree that a copy of this authorization shall be considered as effective and valid as the original.

**Data Transfer:** I hereby give MetLife 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, MetLife branches, affiliates, Reinsurers, business partners, professional advisers, insurance brokers and/or service providers where MetLife believe that the transfer or share, of such personal data is necessary for: (i) the performance of the Policy; (ii) assisting MetLife in the development of MetLife 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 MetLife 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.

#### Declaration

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.

Moreover, I hereby confirm that the funds MetLife is paying will not be transferred, either directly or indirectly, to an OFAC-sanctioned country. These countries currently include Syria, Iran, North Korea, Cuba, Sudan and Crimea.

Signature of Insured  Signature

Date

## Part B - Physician's Statement

### History of Risk Factors:

#### A. Hypertension

Yes  No

If yes , exact date of onset

HTN Questionnaire should be completed by the Doctor who diagnosed this condition first.

#### B. Diabetes Mellitus

Yes  No

If yes , exact date of onset

DM Questionnaire should be completed by the Doctor who diagnosed this condition first

#### C. Dyslipidemia

Yes  No

If yes , exact date of onset

#### D. History of smoking

Yes  No

If yes , no of cigarettes smoked per day and since when

#### E. Ischeamic Heart Disease

Yes  No

If yes , exact date of onset

Name of Attending Physician

Signature of Physician

 Signature

Date

### Need help?

| How to contact us |  |                 |           |           |          |                   |
|-------------------|--|-----------------|-----------|-----------|----------|-------------------|
| Country           | UAE  | Kuwait          | Oman      | Bahrain   | Qatar    | Any other Country |
| Call us           | 800 - MetLife<br>(800 - 6385433)                         | +965 2 208 9333 | 800 70708 | 800 08033 | 800 9711 | +971 4 415 4555   |
| Mail us           | P.O. Box 894, Postal Code 114, Jibroo, Sultanate of Oman |                 |           |           |          |                   |
| E-mail us         | Gulfifeclaims@metlife.com                                |                 |           |           |          |                   |
| Website           | www.metlife-gulf.com/oman                                |                 |           |           |          |                   |

### How to submit the form

Please send **original** documents to:

**Customer Care** - MetLife  
Haffa House Hotel - Ruwi  
- 2nd floor, P.O. Box 894,  
Postal Code 114, Jibroo,  
Sultanate of Oman

**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/oman](http://www.metlife-gulf.com/oman) to see how you can get in touch and learn about our Complaints Handling Process.