

# Loss of Life - Claim Form

## Claimant's Statement



This form should be duly completed and signed by each and every major beneficiary separately. Photocopy of this form may be use when required.

American Life Insurance Company (MetLife)  
Kuwait, P.O. Box 669, Safat 13007, State of Kuwait  
Tel + 965 2 208 9350, Fax + 965 2 208 9334, Gulfclaims@metlife.com

### A. Insured details

1. Deceased's full name  Date of birth

Policy number(s)	Coverage amount(s)	Currency(ies)

All policies listed above should be submitted with your claim except those where the claim is made under Waiver of Premium Benefit.

2. Date of loss of life           Place of loss of life  Residence  Hospital/Clinic  Work place  
 Others, please specify

3. Cause of loss of life

4. Since when has the insured suffered from this condition

5. Occupation at date of loss of life

6. Employer's name

7. Employer's full address

P.O. Box  City / Countries

8. Telephone no.   -   -   E-mail

9. When did the deceased first complain of, or give other indications of his/her last illness (date)

10. When did the deceased first consult a physician for his/her illness (date)

11. Date the deceased last attend to his/her usual work (last working date)

12. Was the Insured smoking?  Yes  No  
If 'yes', how many cigarettes he used to smoke per day and since when?

13. Full name and addresses of all physicians who examined the Insured during his/her last illness and during the five years prior thereto:

Full name	Address	Date of attendance	Illness or condition

14. In what other company(ies), and for what amounts, was the life of deceased insured?

Company(ies)	Policy number(s)	Policy date	Coverage amount

## B. Claimant/Beneficiary Information

1. Full name of applicant/beneficiary
2. Relationship to the Insured  Date of Birth  Age last birthday
3. City of birth  Country of birth
4. 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.

### 5. Occupation

Employment status  Employee  Self-employed

Position / Title  Exact daily duties

Company name  Nature of business

Telephone  Country Code  - Area Code  -  E-mail

### 6. Current residence address

Country  City/Town  P.O. Box

Area/Street  Building  Flat/Villa no.

Telephone  Country Code  - Area Code  -  Mobile  Country Code  - Area Code  -

### 7. In what capacity or by what title, do you claim this insurance?

- Designated beneficiary**
- Legal guardian** (please provide legal guardianship certificate from appropriate with the right to cash proceeds and give valid discharge)
- Successor/Legal heir** (please provide legal succession certificate from appropriate authority appointing the legal heir of the deceased with their names, ages and shares)
- Other** (please specify)

### Bank details of Beneficiary / Payee required for wire transfer

Beneficiary / Payee Name

Beneficiary / Payee Full Address

Mobile No.  Country Code  - Area Code  -  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

The undersigned, hereby makes claim to said insurance, and agrees that the written statements and affidavits of all physicians who attended to or treated the insured shall constitute and they hereby made a part of these Proofs of Death, and further agrees that the furnishing of this form, or of any other forms supplemental thereto, by said Company shall not constitute nor be considered by it that there was any insurance in force of the life in question, nor a waiver of any of its rights or defenses.

Dated at   on this   day of   20

Signature

## Authorization

I,  give my permission

to release information concerning full name of insured who died on (Date of Death) to MetLife including its agents, subsidiary companies and attorneys, reinsurers, insurance support group and independent investigator who are acting on their behalf. Information released may include records of medical advice, medical care, medical treatment of AIDS or AIDS related disease, mental illness, drug or alcohol use, smoking history, other insurance coverage, financial and employment history. This information may be released by medical professionals or facilities, pharmacies, Hospitals, prescription data base suppliers, government offices, employers, insurance companies or any other organization or person having any knowledge of the above named insured. When requesting information from any of the sources named above, a copy of this form is as good as the original. I am aware that any information obtained will be used to judge my claim. I understand that my claim will not be processed unless this authorization is completed and signed. This authorization is valid from the date signed until the claim is resolved.

## Declarations

- 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.
- I also understand that the issuance and continuation of my insurance contract is subject to the regulations applicable to the Company with respect to the international sanctions and I hereby agree that for the purpose of complying with the local and international sanctions including but not limited to the OFAC, UN sanctions, the Company may at its own discretion take any action that it finds appropriate with respect to the issuance, freezing any transaction on my insurance policy, and/or continuation of my insurance policy.
- 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.

**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.

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

## Foreign Account Tax Compliance Act (Fatca) declaration

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

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

## E-mail Declaration

By providing your E-mail address and signing this application you agree to receive from MetLife the policy document, certificate and / or any other documents and to send to MetLife all types of documents and information related to the policy ["Documents"] via electronic mail ["E-mail"]. Please be aware that having chosen this electronic means of sending or receiving information & Documents, it is your responsibility to ensure that the E-mail address you have provided us in this application is correct at all times, and that it is your responsibility to inform MetLife immediately should your E-mail address changes or should you cease to receive the Documents. You agree that all information & Documents sent to or received from your E-mail address as stated in this application will be considered valid and originated from you or sent to you personally.

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](http://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.

Full name in his/her own handwriting  Beneficiary's Name	X Signature  Beneficiary's Signature	D D M M Y Y Y Y  Date
Full name in his/her own handwriting  Witness Name	X Signature  Witness Signature	D D M M Y Y Y Y  Date

### Need help?

How to contact us							How to submit the form
Country	UAE	Kuwait	Oman	Bahrain	Qatar	Any other Country	Please send <b>original</b> documents to:  <b>Customer Care</b> - MetLife Kuwait, P.O. Box 669 Safat 13007, State of Kuwait
Call us	800 - MetLife (800 - 6385433)	+965 2 208 9333	800 70708	800 08033	800 9711	+971 4 415 4555	
Mail us	P.O. Box 669 Safat 13007, State of Kuwait						
E-mail us	Gulflifeclaims@metlife.com						
Website	www.metlife-gulf.com/kuwait						

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