Total Disability Benefits

Claimant's Statement

This statement must be fully answered by the Insured or his duly appointed Guardian or Committee, If insane If, due to physical condition, Insured in unable to answer there questions beneficiary or nearest relative may do so.

▶ Please provide all relevant information completely and legibly.

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, Gulflifeclaims@metlife.com

1. **Full name of the Insured**

2. **Policy & certificate number**

3. **Occupation** **Daily Duties**

4. **(a) Insured's date of birth** D D M M Y Y Y Y **(b) Place of birth**

5. **Height** **Weight**

6. **Describe fully the Insured's present condition**

7. **To what extent is the Insured unable to follow any/similar occupation?**

8. **Give date of injury/ailment or beginning of illness causing present condition** D D M M Y Y Y Y

9. **When was the Insured compelled to give up part of his duties** D D M M Y Y Y Y

10. **When was the Insured compelled to give up all of his duties?** (Give exact date) D D M M Y Y Y Y

11. **Has Insured done any kind of work since commencement of disability?** If so, give particulars

12. **When does the Insured expect to return to work?** D D M M Y Y Y Y

13. **Give name and address of every physician or practitioner who attended or prescribed for the Insured during present affliction**

a. Duration	b. Name of Physician or Practitioner	c. Address
From __ __ 20 __ __ to __ __ 20 __ __		
From __ __ 20 __ __ to __ __ 20 __ __		
From __ __ 20 __ __ to __ __ 20 __ __		

14. **For what disease, injury, ailment or has the Insured required the services of a physician or practitioner prior to present disease?**

a. Name of injury, diseases, etc.	b. Duration	c. Name of Physician or Practitioner	d. Address
	From __ __ 20 __ __ to __ __ 20 __ __		
	From __ __ 20 __ __ to __ __ 20 __ __		
	From __ __ 20 __ __ to __ __ 20 __ __		

15. **Is the Insured's estate represented by a Committee or Guardian?** (If so, furnish copy of appointment) ..... ☐ **Yes** ☐ **No**

16. **What other life, government, health or accident insurance providing for disability benefits to the Insured?**

a. Duration	b. Name	c. Address

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

Declarations

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated, or in now treating me, to impart to MetLife any information it my desire.

"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.

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

Full name of the Insured Signature of Insured X

Signed at City Country D D M M 20 Y Y Day Month Year

Need help?

How to contact us						
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
Mail us	P.O. Box 894, Postal Code 114, Jibroo, Sultanate of Oman					
E-mail us	Gulflifeclaims@metlife.com					
Website	www.metlife-gulf.com					

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 to see how you can get in touch and learn about our Complaints Handling Process.