

# Medical and Hospitalization Claim Form



American Life Insurance Company (MetLife)

Bahrain, Airport Road, P.O. Box 20281, Manama - Kingdom of Bahrain

T. +973 1 755 6608, F. +973 1 731 1229 - Gulfifeclaims@metlife.com

▶ Complete the form in capital letters.

Insured's full name*	<input type="text"/>	Date of birth*	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Insured's nationality*	<input type="text"/>									
Certificate number* <small>(Mentioned on your Medical Card)</small>	<input type="text"/>									

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

Beneficiary / Payee Name	<input type="text"/>									
Beneficiary / Payee Full Address	<input type="text"/>									
Mobile No.	<input type="text"/>	Country Code	<input type="text"/>	Area Code	<input type="text"/>	E-mail	<input type="text"/>			
Bank Name	<input type="text"/>					Currency Account	<input type="text"/>			
Bank Address	<input type="text"/>									
Bank Account Holder Name	<input type="text"/>									
Bank Account No.	<input type="text"/>					Swift Code	<input type="text"/>			
IBAN No.	<input type="text"/>									

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

Signature	<input type="text"/>
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## Authorization Statement

- I hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide MetLife (American Life Insurance Company) with the complete information's, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

## Disclaimer

- I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company. I also accept and recognize that at the sole discretion of the MetLife, these documents may be requested at any time during a period of one year counted from the submission of the claim, which I will provide within a period not exceeding of 30 days from the request. Failing to comply could imply the claim to be declined. If the case is confirmed to be declined, I will reimburse any amount paid by MetLife to me or to any party as related to this claim.
- I hereby provide 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 the Company Headquarters in the USA, its branches, affiliates, Reinsurers, business partners, professional advisers, Insurance Brokers and/or service providers where the transfer or share, of such personal data is necessary for: (i) the performance of this Policy; (ii) assisting the Company in the development of its business and products; (iii) improving the Company's 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 the Company.

\***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.

Employee's signature	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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## 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 Bahrain, Airport Road P.O. Box 20281 Manama - Kingdom of Bahrain T. +973 1 755 6608 F. +973 1 731 1229
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 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](http://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

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## Attending Physician Section (\*Mandatory fields)

### To be filled by attending physician

Patient's full name  Date of birth

Chief complains\*

Diagnosis\*

### How long has the patient been suffering from this sickness?\*

Please specify the date when then symptoms first appeared:

If treated by other medical provider please specify the name and treatment details:

Details of the treatment (other than prescription):

If further treatment or operative procedure anticipated, please provide the details:

Physician's name, address and tel. no.

E-mail ID

Physician's Signature and Stamp

## Checklist for Insured member

Required	Check box	Documents	Notes
Yes	<input type="checkbox"/>	Claim Form (including Attending Physician Section)	Fully completed and signed by you and your physician/surgeon
Yes	<input type="checkbox"/>	Detailed medical report	Detailing ailment/diagnosis or accident with dates it started/happened, signed by your treating physician
Yes	<input type="checkbox"/>	Original hospital/clinic bill	Original
If applicable	<input type="checkbox"/>	Copy of all relevant X-rays/Echography /MRIs and reports	Should reflect your name and date they were taken
If applicable	<input type="checkbox"/>	Copy of all lab tests and reports	Only related to this incident
If applicable	<input type="checkbox"/>	Copy of police report	Required if claim relates to an accident

### Please remember:

To help us process your insurance claim as quickly as possible, we ask you to provide the above documents. Otherwise your claim could be delayed or potentially rejected.

### How to submit the claim

Login to myMetLife **OR** Please contact your H.R. for the claim submission process