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.

▶ Please provide all relevant information completely and legibly.

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, Gulflifeclaims@metlife.com

Claimant's statement

1) **Full name of Insured** _____ Date of birth D D M M Y Y Y Y

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:

Physician's statement on other side

Attending physician _____ M.D.

Sign your full name _____ Dated D D M M Y Y Y Y

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

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.

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 669 Safat 13007, State of Kuwait					
E-mail us	Gulflifeclaims@metlife.com					
Website	www.metlife-gulf.com					

How to submit the form

Please send **original** documents to:

Customer Care - MetLife Kuwait, P.O. Box 669 Safat 13007, State of 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 to see how you can get in touch and learn about our Complaints Handling Process.

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Registration No. 7245

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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 D D M M Y Y Y Y
3. **When did patient first consult you for this condition?** Date D D M M Y Y Y Y
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** D D M M Y Y Y Y
   (c) If 'no', is it anticipated? ☐ **Yes** ☐ **No** **(d) When?** Approximate date D D M M Y Y Y Y
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 D D M M Y Y Y Y
    (c) Where was it performed?
    (d) If in hospital ☐ In patient ☐ Out patient
11. **Give dates of treatment.** Office D D M M Y Y Y Y Home D D M M Y Y Y Y
    Hospital D D M M Y Y Y Y
12. **(a) Is the patient still under your care for this condition?** ☐ **Yes** ☐ **No** **(b) If discharged, give date** D D M M Y Y Y Y
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) X Date D D M M Y Y Y Y

Telephone Include country and area code Street Street address

City/Town State/Province Zip code

Claimant's statement on other side