# **Dismemberment Claim Report**



## CL-20 Partial Disability Form

		d person (if infant, by parent or guardian int information completely and legibly.		-	Kuwait, P.O. Box 66	nsurance Company (MetLife) 9, Safat 13007, State of Kuwai		
			Tel	+ 965 2 208 9350,	Fax + 965 2 208 933	34, Gulflifeclaims@metlife.com		
Cla	aimant's statement							
1)	Full name of Insured	k			Date of birth	D M M Y Y Y Y		
	Current address				Policy no.			
2)	(a) Give full descrip	tion of injury and tell where, how ar	nd when did it happe	n?				
	(b) Give full descrip	b) Give full description of injury/sickness and tell where, how and when did it happen?						
3)	Hospitals (Give com	Hospitals (Give complete names, addresses, and dates of confinement)						
	Name	Address		Fro	m	То		
	Name	Address		Fro	m	То		
4)	(a) Give names and	addresses of all physicians who hav	ve treated you for thi	s injury				
	Name		Address					
	(b) Give name and a	ddress of usual family physician						
	Name		Address					
5)	What other acciden	t, sickness or disability insurance d	<b>o you carry?</b> (Name o	companies, societ	ties, etc., and desc	cribe benefits).		
	Name		Address					
	Benefits							
6)	What other medical	or surgical treatment has been rec	eived during the pas	t five years? (Giv	ve dates, nature of	illnesses, or injuries and		
	names and addresses	s of attending physicians and names a	ind addresses of clinic	s or hospitals wh	ere treated)			
					Dhusisian's	etetement en ether eide		
	<b>proved by:</b> ending physician				rnysician's	statement on other side M.D.		
	n your full name		1 of 3	D	ated DDM			

#### 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.

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 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.

### Need help?

How to contact us							How to submit the form
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	Please send <b>original</b> documents to:
Mail us	Mail us         P.O. Box 669 Safat 13007, State of Kuwait						<b>Customer Care</b> - MetLife Kuwait, P.O. Box 669 Safat
E-mail us	E-mail us Gulflifeclaims@metlife.com						13007, State of Kuwait
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 <u>www.metlife-gulf.com/kuwait</u> to see how you can get in touch and learn about our Complaints Handling Process.

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Partent's name Age   1. Nature of injury (Describe complications if any)   2. When did symptoms first appear or accident happen?   3. When did patient first consult you for this condition?   4. (a) Has the patient even had the same or similar condition?   (b) If 'yes', state when and describe   5. (c) Is dismemberment or loss of sight due solely to injuries sustained in the accident?   7. Loss of sight new   (c) If no', describe and disease or infirmity affecting injury   6. Diamemberment   Describe sotul place of severance   7. Loss of sight and irrecoverable?   (c) If no', is it anticipated?   (d) Is a comstal transplant or loss of sight?   (e) If no', is it anticipated?   (f) If no', is it anticipated?   (g) Is a comstal transplant or loss of sight?   (g) Is a comstal transplant or loss of sight?   (h) If some and explain fully   9. (a) Status of vision, lift none, state none)   Right eve   (g) Describe any disease of infirmity affecting sight prior to injury   (h) Present status of vision, lift none, state none)   Right eve   (f) Describe any disease of infirmity affecting sight prior to injury   (h) Nature of surgical procedure, if any (describe fully)   (h) Date performed   (c) Where was it performed?   (d) If in hospital   (e) Notice so it reading physicians   Houghtal   (f) If the patient still under your care for this condition?   (g) Is the patient still under your care for this condition?   (h) If	At	tending Physician's Statement							
2. When did symptoms first appear or accident happen? Date  3. When did patient first consult you for this condition? Date  3. When did patient even had the same or similar condition? Date  3. (a) Has the patient even had the same or similar condition? The  3. (b) If 'ye's, state when and describe  3. (c) If diamemberment or loss of sight due solely to injuries sustained in the accident? Yes  4. (a) It is of sight entire and irrecoverable? Yes  4. (b) If 'no', describe any disease or infirmity affecting injury  4. (c) It is no's it anticipate? Yes  4. (c) Status of vision prior to injury  4. (c) Status of vision prior to injury  4. (c) Present status of vision, (if none, state none)  4. (c) Present status of vision, (if none, state none)  4. (c) Describe any disease of infirmity affecting sight prior to injury  4. (c) Describe any disease of infirmity affecting sight prior to injury  4. (c) Describe any disease of infirmity affecting sight prior to injury  4. (c) Describe any disease of infirmity affecting sight prior to injury  4. (c) Where was it performed?  4. (d) It in hospital I In patient  4. (d) It is hospital	Pat	ient's name				Age			
3. When did patient first consult you for this condition?       Date       Image: Construct the same or similar condition?         4. (a) Has the patient ever had the same or similar condition?       Types       No         (b) If 'ye's, state when and describe       No         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            (a) Is a dismemberment             Describe actual place of severance             7. Loss of sight entire and irrecoverable?       Yes       No (d) When?       Approximate date            6. (d) Is acorsel 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                                   <	1.	Nature of injury (Describe complic	ations if any)						
4. (a) Has the patient ever had the same or similar condition?       Yes       No         (b) If 'ye's, state when and describe	2.	When did symptoms first appear	or accident happen? Date	D D M M	Y Y Y	Y			
(b) If Yys'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 as of sight entire and irrecoverable? Yes No (b) If 'yes', give exact date it occurred (c) If 'no', is it anticipated?         (b) If 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         (b) Present status of vision prior to infirmity affecting sight prior to injury         10. (a) Nature of surgical procedure, if any (describe fully)         (c) Describe any disease of infirmity affecting sight prior to injury         10. (a) Nature of surgical procedure, if any (describe fully)         (b) Date performed         (c) Where was it performed?         (d) If in hospital         (e) State sof under your care for this condition?         Yes       No         (b) State performed?         (c) Where was it performed?         (d) If in hospital         (e) State addresses of all other attending physicians         It the patient was hospitalized, give names and addresses of hospitals and dates of	3.	When did patient first consult yo	u for this condition? Date		YYY	Y			
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         (c) If so's is anticipated?         Yes       No         (a) Is loss of sight entire and irrecoverable?       Yes         (b) If so's is anticipated?       Yes         (c) If 'no', is it anticipated?       Yes         8. (a) Is a corneal transplant or other surgery or treatment contemplated to recover all or any part of this loss of sight?       Yes         9. (a) Status of vision prior to injury       No (b) If 'ye's, state when and explain fully         9. (b) Present status of vision. (If none, state none)       Night eye         (c) Describe any disease of infirmity affecting sight prior to injury       Iceft Eye         10. (a) Nature of surgical procedure, if any (describe fully)       (b) Date performed?         (c) Where was it performed?       In patient         (d) If in hospital       In patient         11. Give dates of treatment.       Office         12. (a) Is the patient was hospitalized, give names and addresses of hospitals and dates of confinement         13. If the patient was hospitalized, give names and addresses of hospitals and dates of confinement         14. Give names and addresses of all other attending physicians	4.	(a) Has the patient ever had the s	ame or similar condition?	/es No					
(b) If 'no', describe any disease or infirmity affecting injury         6. Dismemberment         Describe actual place of severance         (c) Is loss of sight         (a) Is loss of sight antire and irrecoverable?         (b) If 'no', is it anticipated?         Yes       No         (c) If 'no', is it anticipated?         Yes       No         (c) If 'no', is it anticipated?         Yes       No         (b) If 'ye's, state when and explain fully         9. (a) Status of vision prior to injury         Right eye       /         (c) Describe any disease of infirmity affecting sight prior to injury         (c) Obscribe any disease of infirmity affecting sight prior to injury         (c) Where was it performed?         (c) Where was it performed?         (c) Where was it performed?         (d) If in hospital         In patient         Out patient         It the patient was hospitalized, give names and addresses of hospitals and dates of confinement         It describe any addresses of all other attending physicians         12. (a) Is the patient was hospitalized, give names and addresses of hospitals and dates of confinement         13. If the patient was hospitalized, give names and addresses of hospitals         14. Give names and addresses of all other attending physicians </th <th></th> <th>(b) If 'ye's, state when and descri</th> <th>ibe</th> <th></th> <th></th> <th></th>		(b) If 'ye's, state when and descri	ibe						
	5.	(a) Is dismemberment or loss of s	sight due solely to injuries susta	ined in the accident?	Yes	No			
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         (c) If 'no', is it anticipated?       Yes         No       (d) When?       Approximate data         (e) If 'no', is it anticipated?       Yes         No       (d) When?       Approximate data         (e) If 'no', is it anticipated?       Yes         No       (d) When?       Approximate data         (e) If 'no', is it anticipated?       Yes         No       (d) When?       Approximate data         (e) If 'ye's, state when and explain fully		(b) If 'no', describe any disease of	r infirmity affecting injury						
(a) Is loss of sight entire and irrecoverable? Yes No (b) If 'yes', give exact date it occurred Image: Sight entire and irrecoverable? Yes No (c)   (c) If 'no', is it anticipated? Yes No (d) When? Approximate date Image: Sight entire and irrecoverable? Yes No   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 Image: Sight eye / Image: Sight eye /   9. (a) Status of vision prior to injury Right eye / Image: Sight eye /   (b) Present status of vision. (If none, state none) Right eye / Image: Sight eye /   (c) Describe any disease of infirmity affecting sight prior to injury Image: Sight eye / Image: Sight eye   (c) Ansure of surgical procedure, if any (describe fully) Image: Sight eye Image: Sight eye Image: Sight eye   (d) If in hospital Image: Sight eye Image: Sight eye Image: Sight eye Image: Sight eye   12. (a) Is the patient still under your care for this condition? Yes No No   13. If the patient was hospitalized, give names and addresses of hospitals and dates of confinement   Image: Signeture (attending physicians)   Image: Signeture (attending physician)	6.								
(c) If 'no', is it anticipated? Yes No (d) When? Approximate date   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	7.			) If 'vos' give event d	ata it agaurra				
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         (b) Present status of vision. (If none, state none)         Right 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         (c) Where was it performed?         (d) If in hospital         In petient         11. Give dates of treatment.         Office         Hospital         In petient         12. (a) Is the patient still under your care for this condition?         Yes       No         13. If the patient still under your care for this condition?         Yes       No         (a) Is no patial       Address         In patient         14. Give names and addresses of hospitals and dates of confinement         15. In condition due to injury arising out of the patient's employment?       Yes         No         Signature (attending physician)       Street         Telephone       Street       Street		-							
(b) If 'ye's, state when and explain fully         9. (a) Status of vision prior to injury       Right eye         (b) Present status of vision. (If none, state none)       Right 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       Image: Street infirmity affecting is the fully         (c) Where was it performed?       Image: Street infirmity affecting is the fully         (d) If in hospital       Image: Street infirmity affecting is the fully?         12. (a) Is the patient still under your care for this condition?       Yes         No       (b) If discharged, give date       Image: Street infirment         If the patient still under your care for this condition?       Yes       No         (a) Is the patient still under your care for this condition?       Yes       No       (b) If discharged, give date       Image: Street infirment         If the patient was hospitalized, give names and addresses of hospitals and dates of confinement       Image: Street infirment       Image: Street infirment         If Give names and addresses of all other attending physicians       Image: Street infirment?       Yes       No         Signature (attending physician)       Image: Street infirment?       Yes       No       Street infirment?	8								
(b) Present status of vision. (If none, state none)       Right eye       /       Left Eye       /         (c) Describe any disease of infirmity affecting sight prior to injury	0.								
(c) Describe any disease of infirmity affecting sight prior to injury         (a) Nature of surgical procedure, if any (describe fully)         (b) Date performed       (a)	9.	(a) Status of vision prior to injury	Right eye	/	Left Eye				
10. (a) Nature of surgical procedure, if any (describe fully)         (b) Date performed         (c) Where was it performed?         (d) If in hospital         In patient         Out patient         11. Give dates of treatment.         Office         Image: Description of the patient semployment?         Image: Description of the patient's employment?         Yes         Name         Address         Image: Description of the patient's employment?         Yes       No         Signature (attending physician)         Telephone       Notice contry and area code		(b) Present status of vision. (If none	, state none) Right eye	/	Left Eye				
(b) Date performed       Image: Control of the patient         (c) Where was it performed?       Image: Control of the patient         (d) If in hospital       Image: Control of the patient         11. Give dates of treatment.       Office         Image: Control of the patient       Image: Control of the patient         12. (a) Is the patient still under your care for this condition?       Yes         No       (b) If discharged, give date       Image: Control of the patient         13. If the patient was hospitalized, give names and addresses of hospitals and dates of confinement         Hospital       Address       From         Hospital       Address       From         14. Give names and addresses of all other attending physicians       Address         15. In condition due to injury arising out of the patient's employment?       Yes       No         Signature (attending physician)       Date       Image: Control of the patient's employment?       Yes       No         Signature (attending physician)       Street       Street address       Street address       Street address		(c) Describe any disease of infirm	nity affecting sight prior to injur	у					
(c) Where was it performed?         (d) If in hospital         In patient         Out patient         11. Give dates of treatment.         Office         Image: Street         Hospital         Image: Street address	10.	(a) Nature of surgical procedure,	if any (describe fully)						
(d) If in hospital       In patient       Out patient         11. Give dates of treatment.       Office									
11. Give dates of treatment.       Office       O       O       V		(c) Where was it performed?							
Hospital       Hospital <td< th=""><th></th><th>(d) If in hospital</th><th>In patient</th><th>Out patient</th><th></th><th></th></td<>		(d) If in hospital	In patient	Out patient					
12. (a) Is the patient still under your care for this condition?       Yes       No       (b) If discharged, give date       Image: Condition of the patient was hospitalized, give names and addresses of hospitals and dates of confinement         13. If the patient was hospitalized, give names and addresses of hospitals and dates of confinement         Hospital       Address       From       To         Image: Address of all other attending physicians       Image: Address       Image: Address         14. Give names and addresses of all other attending physicians       Address       Image: Address         Image: Address of all other attending physicians       Image: Address       Image: Address         Image: Address of all other attending physicians       Image: Address       Image: Address         Image: Address of all other attending physicians       Image: Address       Image: Address         Image: Address of all other attending physicians       Image: Address       Image: Address         Image: Address of all other attending physicians       Image: Address       Image: Address         Image: Address of all other attending physician       Image: Address       Image: Address         Image: Address of all other attending physician       Image: Address       Image: Address         Image: Address of all other attending physician       Image: Address of all other attending physician       Image: Address         Im	11.			Home DDMN	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         Image: Second s	12.			No (b) If discharg	ed, give date				
14. Give names and addresses of all other attending physicians         Image: Name       Address         Image: Name       Name         Image: Name       Image: Name         Im	13.	If the patient was hospitalized, gi	ve names and addresses of hos	pitals and dates of con	finement				
Name     Address       15. In condition due to injury arising out of the patient's employment?     Yes     No       Signature (attending physician)     Date     D     M     Y     Y       Telephone     Include country and area code     Street     Street address		Hospital	Address	From		То			
Name     Address       15. In condition due to injury arising out of the patient's employment?     Yes     No       Signature (attending physician)     Date     D     M     Y     Y       Telephone     Include country and area code     Street     Street address									
Name     Address       15. In condition due to injury arising out of the patient's employment?     Yes     No       Signature (attending physician)     Date     D     M     Y     Y       Telephone     Include country and area code     Street     Street address									
15. In condition due to injury arising out of the patient's employment?       Yes       No         Signature (attending physician)       Date       D       M       Y       Y         Telephone       Include country and area code       Street       Street address       Street address	14.			Address					
Signature (attending physician)     Date     D     M     Y     Y       Telephone     Include country and area code     Street     Street address			Autess						
Signature (attending physician)     Date     D     M     Y     Y       Telephone     Include country and area code     Street     Street address									
Telephone     Include country and area code     Street     Street address	15.	In condition due to injury arising	out of the patient's employmen	t? Yes No					
	Signature (attending physician)					ate DDMMYYYY			
City/Town State/Province Zip code		Telephone Include country and area	a code Street		Street addre	255			
		City/Town	State/Province		] Zip co	de			

Claimant's statement on other side