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	o you carry? (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		
	proved by: 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 original documents to:
Mail us	Mail us P.O. Box 669 Safat 13007, State of Kuwait						Customer Care - 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							
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Claimant's statement on other side