Total Disability Benefits

Claimant's Statement

Gulf Operations
P.O. Box 371916, Dubai, UAE - Tel. 04 415 4555, Fax 04 415 4445

▶ Please provide all relevant information completely and legibly.

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.

1. **Full name of the Insured**
2. **Occupation** **Daily Duties**
3. **(a) Insured's date of birth** D D M M Y Y Y Y **(b) Place of birth**
4. **Height** **Weight**
5. **Describe fully the Insured's present condition**
6. **To what extent is the Insured unable to follow any occupation?**
7. **Give date of injury or beginning of illness causing present condition** D D M M Y Y Y Y
8. **When was the Insured compelled to give up part of his duties** D D M M Y Y Y Y
9. **When was the Insured compelled to give up all of his duties?** (Give exact date) D D M M Y Y Y Y
10. **How does the Insured spend his time?**
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 affliction has the Insured required the services of a physician or practitioner prior to present affliction?**

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. **Has either of Insured's parents or any of his brothers or sisters or other relative been afflicted with a similar disease?** .... ☐ **Yes** ☐ **No**
If so, give particulars
16. **Is the Insured's estate represented by a Committee or Guardian?** (If so, furnish copy of appointment) ..... ☐ **Yes** ☐ **No**
17. **What other life, government, health or accident insurance providing for disability benefits to the Insured?**

a. Duration	b. Name	c. Address

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."

Full name of the Insured | Signature of Insured X

Signed at | | D D M M 20 Y Y

City | Country | Day | Month | Year

Need help?

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