Group Insurance
Individual Enrollment Form

American Life Insurance Company
WILMINGTON, DELAWARE, U.S.A., INCORPORATED 1921

GULF OPERATIONS
P.O. Box 371916, Dubai, United Arab Emirates

IMPORTANT NOTICE - To expedite the approval of insurance coverage, do not leave any questions, unanswered, provide medical reports, dates and / or signatures, wherever applicable. To expedite processing any maintenance request on insured Employees, indicate under Part B, the individual Employee's Cert. No. per MetLife records / billings / enrollment lists. MetLife reserves the right to request medical evidence of insurability and to accept or reject any application as per its underwriting standards.

Please tick appropriate box ☐ New Enrollee ☐ Addition of Dependent ☐ Change of Beneficiary ☐ Change of Salary ☐ Change of Class / Subgroup

PART A - TO BE COMPLETED BY EMPLOYEE IF REQUESTING INSURANCE FOR SELF

1. Employee's Details (As shown in the Passport)

First Name ______ Middle Name ______ Last Name ______

Date of Birth D D M M Y Y Y Y Country of Birth ______ Nationality ______

Passport ID No. ______ National ID ______ Country of Res ______

Gender ☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced / Separated ☐ Widowed

Height ____ ft. ____ in. or ____ cm Weight ____ lbs. or ____ kg.

2. Employer's Name / Policyholder's Name

Name ______ City / Country ______ P.O. Box ______

GENERAL QUESTIONS

		Yes	No
3.	**Do you fly other than as a passenger on an aircraft in regularly scheduled common carrier for passenger service?**	☐	☐
4.	**Are you involved in any dangerous sports such as professional sports, mountaineering, diving, parachuting, racing, horse riding?**	☐	☐
5.	**Have you consulted a physician for any illness during the past three years or are you currently under any form of medical treatment or intend to seek medical advice, treatment or have any medical test performed?**	☐	☐
6.	**Has any application for insurance on your life been declined, postponed, or modified, or do you know of any impairment in your health or physical condition?**	☐	☐
7.	**Have you ever been treated for or told you had or intended to seek medical advice, treatment or medical test performed for heart disease, high blood pressure, diabetes, or sugar in your urine, kidney disease, lung disease, cancer, disorder of the back or joints, nervous disorder or disorder of the stomach or abdominal organs?**	☐	☐
8.	**If female, are you pregnant? (If yes, state duration ______)**	☐	☐
9.	**AIDS (Acquired Immune Deficiency Syndrome) Question - Describe in detail any affirmative answers:** Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or sexually transmitted disease? Have you been told you had AIDS or AIDS complex? Have you had or been told you had a positive blood test for antibodies to the AIDS virus? or Do you have any of the following which are unexplained: fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions?	☐	☐

If answer is "Yes" to any of the above questions 5 to 9, please give full particulars below (If reason for consultation is check-up, please indicate exact reason, date performed, type of exam performed and attach any available results). Use separate sheet if necessary and attach copies of hospital discharge reports and up-to date medical report from treating physician.

Question No.	Details of Condition	Duration of Condition	Date of Treatment	Complete Recovery Month Year	Name & Address of Physician or Hospital

10. Beneficiaries for death benefits only (please also complete Part C on the reverse if requesting medical insurance for your dependents)

Beneficiary's Full Name	Address	Beneficiary ID *(Emirates ID / Passport No.)*	Nationality	Date of Birth	Relationship to Employee	Percentage of Proceeds

If nothing is specified under the Percentage of Proceeds above then equal split between/among Beneficiaries. If any Beneficiary listed above dies before me, the interests of such Beneficiary shall, unless otherwise provided above, accrue to the surviving Beneficiaries or Beneficiary or if none to my estate. I reserve the right to change any Beneficiary named above by notifying MetLife through completion of another Beneficiary Designation Form.

"I hereby understand and agree that no action at law can be brought by me or by my dependents, beneficiaries or by any third party in respect to any claim under the Group Policy except with the written consent of the Group Policyholder".

Date D D M M Y Y Y Y X Policyholder's Signature & Stamp X Employee's Signature

For MetLife use only

MetLife's Cert No.		Group Policy No.		Effective Date	
Underwriter's Comments		Date & Underwriter's Initial		Other Comments	

PART B - TO BE COMPLETED BY EMPLOYER / POLICYHOLDER

1. **Employer's Name / Policyholder's Name**

   Name | City / Country | P.O. Box

2. **Employee's Name (As shown in the Passport)**

   Name | Employment Date D D M M Y Y Y Y | Group Policy No.

   Class/Subgroup No. | Plan No. | Employee's Cert. No. per MetLife's record

   Occupation | Annual Salary Provide if volume is a multiple of salary | Currency

   Coverage Requested

3. **From a health standpoint, do you know of any reason why the employee or any of his dependents should not be insured or has the employee been absent from work because of sickness or injury during the past six months?** If "yes", please give full details and dates.

4. **Requested Date of Coverages** D D M M Y Y Y Y

PART C - TO BE COMPLETED BY EMPLOYEE IF REQUESTING MEDICAL INSURANCE FOR DEPENDENTS

1. **Dependents details (spouse & dependent children only)** (If more space needed, complete additional form)

Dependent Full Name	Nationality	National ID No.	Relationship To Employee			Date of Birth	Height	Weight	For MetLife's use only Dependent's Effective Date
			Spouse	Son	Daughter		Cm.	Kg.	
						D D M M Y Y Y Y			
						D D M M Y Y Y Y			
						D D M M Y Y Y Y			
						D D M M Y Y Y Y			
						D D M M Y Y Y Y			

2. **Name and address of any dependent if living outside your country of work residence for more than six months in a year.**

3. **Have any of your dependents named above:** **Yes** **No**

   a) Consulted a physician for any illness during the past five years or is currently under any form of medical treatment or intend to seek medical advice, treatment or have any medical test performed? .... ☐ ☐

   b) Has any application for insurance on their life been declined, postponed, or modified, or do you know of any impairment in their health or physical condition? .... ☐ ☐

   c) Been treated for or told they had or intent is seek medical advice, treatment or medical test performed for heart disease, high blood pressure, diabetes, or sugar in their urine, kidney disease, lung disease, cancer, disorder of the back or joints, nervous disorder or disorder of the stomach or abdominal organs? .... ☐ ☐

4. **To be answered by married male employees only. Is your spouse pregnant? (If yes, state duration)** ..... ☐ ☐

5. **AIDS (Acquired Immune Deficiency Syndrome) Question - Describe in detail any affirmative answers:**
   Have you received medical advice, or treatment, in connection with AIDS or an AIDS related condition or sexually transmitted disease?
   Have you been told you had AIDS or AIDS complex? Have you had or been told you had a positive blood test for antibodies to the AIDS virus? or
   Do you have any of the following which are unexplained: fatigue, weight loss, diarrhea, enlarged lymph nodes or unusual skin lesions? .... ☐ ☐

   If answer is "Yes" to any of the above questions 3 to 5, please give full particulars below (If reason for consultation is check-up, please indicate exact reason, date performed, type of exam performed and attach any available results). Use separate sheet if necessary and attach copies of hospital discharge reports and up-to date medical report from treating physician.

Name of Dependent	Question No.	Details of Condition	Duration of Condition	Date of Treatment	Complete Recovery Month Year	Name & Address of Physician or Hospital

- I hereby provide MetLife my unambiguous consent to process, share, and transfer my personal data to a recipient outside the country (e.g. to the Company Headquarters in the USA and / or to other branches or affiliates of the Insurer's Group and Reinsurer) where the transfer, sharing, is necessary for the performance of the contract or for the compliance with any legal obligation to which the Company is subject and where necessary transfer, share any such information with the regulators and other law enforcement agencies for the performance of its obligations related to the international sanctions and other regulations applicable to the Company.
- I also understand that the issuance and continuation of my insurance contract is subject to the regulations applicable to the Company with respect to the international sanctions and I hereby agree that for the purpose of complying with the local and international sanctions including but not limited to the OFAC, UN sanctions, the Company may at its own discretion take any action that it finds appropriate with respect to the issuance, freezing any transaction on my insurance policy, and / or continuation of my insurance policy.

PART D - EMPLOYEE'S AND EMPLOYER'S / POLICYHOLDER'S SIGNATURE

I hereby certify that all statements and all answers to questions appearing on both sides of this form are complete and true to my knowledge. I hereby authorize any doctor, hospital, clinic or medical provider, an insurance company or any other company, institution or any other person who has any record or information about me and/or any of my dependents to provide MetLife with the complete information, including copies of their records with reference to any sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be valid as the original copy.

Date D D M M Y Y Y Y

X Policyholder's Signature & Stamp

X Employee's Signature

For MetLife use only

MetLife's Cert No.		Group Policy No.		Effective Date	
Underwriter's Comments		Date & Underwriter's Initial		Other Comments	

MetLife, Inc. (NYSE: MET), through its subsidiaries and affiliates ("MetLife"), is a leading global provider of insurance, annuities and employee benefit programs. MetLife holds leading market positions in the United States, Japan, Latin America, Asia, Europe and the Middle East.

MetLife is a pioneer of life insurance with a presence of more than 50 years in the Gulf. Through its affiliates in Bahrain, Kuwait, Oman, Qatar and the United Arab Emirates, MetLife offers life, accident and health insurance along with retirement and savings products to individuals and corporations.

For more information, visit www.metlife.com

American Life Insurance Company is a MetLife, Inc. Company

American Life Insurance Company
WILMINGTON, DELAWARE, U.S.A.
INCORPORATED 1921

MetLife®

www.metlife-gulf.com

MET/CSO/G42-IEF/04-14
® MetLife