American Life Insurance Company

Claimant`s Statement

Total or partial disability benefits

This statement must be fully answered by the Insured or his duly appointed Guardian or Committee, If insane If,, due to physical condition., Insured is unable to answer these questions beneficiary or nearest relative may do so,

1- Full name of Insured _____ 2- Occupation (state exact duties in full) _____

3- (a) Date of Insured's birth
(Month) ☐ (Day) ☐ (Year) ☐

(b) Place of birth (Town) ☐ (Country) ☐ (State) ☐

4-Height ____ feet ____ Inches Weight ____ pounds

5- Describe fully Insured's present condition

6- To what extent is Insured unable to follow any occupation?

7- Give date of injury or beginning of illness causing persent condition
(Month) ☐ (Day) ☐ (Year) ☐

8- When was Insured compelled to give up part of his duties?
(Town) ☐ (Country) ☐ (State) ☐

9- When was Insured compelled to give up all of his duties? (Give exact date)
(Month) ☐ (Day) ☐ (Year) ☐

10- How does Insured spend his time?

11- Has Insured done any kind of work since commencement of disability? If so, give particulars

12- When does Insured expect to return to work?

13- Give name and address of every physician or practitioner who attended or prescribed for 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 afiction has Insured required the services of a physician or practitioner prior to present affliction

a. Name of injury, disease, 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 bee afflicted with a similar disease? If so, give particulars

16- Is Insured's estate represented by a Committee or Guardians (If so, furnish copy of appointment)

17- What other Life, Government, Health or Accident Insurance providing for disability benefits have you?

a. Name of Company	b. Address	c. Amount of weekly or monthly indemnity

I hereby authorize any hospital to which I have been confined and any physician or practitioner who has treated or is now treating me, to impart to **American life insurance company** any information it may desire.

Sworn to before me this _____

day of _____ 20 ____

Notary Public

Signature of Insured _____

Residence _____

No. Street City

State

Statement No. 1

Commercial register no. 3623 on 13 July 1953 and registered in the register of insurance companies Sub. No. 30 on 29 November 1956, Governed by the insurance regulation law Decree no. 9812 as of May 1968 4 and its amendments.
Address: JM Plaza, Concorde Square, Verdun, Beirut- Lebanon. Contact number: 9611352752+ (Fax ext. 1616) and E-mail: service-lebanon@metlife.com

American Life Insurance Company

Attending physican`s statement — Total or partial disability benefits

By giving full and complete answers, the Attending Physician will assist the Company in passing promptly on the claim. This statement to be furnished without expense to the Company.

1. Full name of Instm!d. _____

2. Where is Insured now located? (H an inmate of a hospital or other institution give name and address).

_____

3.How long have you been Instm!d's medical advisor?

_____

4.When did Insured's health first become affected?

(Month) ☐ (Day) ☐ (Year) ☐

5.Give Symptoms, Diagnosis and Prognosis of Disability.

_____

6.(a) Is Insured wholly disabled and prevented from engaging in any business or occupation whatsoever?

_____

6.(b) H he is, from what date, to your knowledge, has he been so prevented?

(Month) ☐ (Day) ☐ (Year) ☐

7.(a) Date of your first visit or prescription in present affliction.

(Month) ☐ (Day) ☐ (Year) ☐

7.(b) Date of your last visit or prescription in present affliction.

(Month) ☐ (Day) ☐ (Year) ☐

8.Is Instm!d now confined to his bed or house? State which. and from what date?

_____

(Month) ☐ (Day) ☐ (Year) ☐

9. When, in your opinion, may Insured be expected to do any kind of work?

_____

10.Have you or any other physicians or practitioners attended or treated Insured for any cause whatsoever prior to present affliction?

a. Nature of diseases or injuries?	b. Dates of attendance	c. Name of physician or Practitioners	d. Address
	From To		
	From To		
	From To		

11.Has Insured ever received treatment for specific disease? H so, give particulars.

_____

_____

12. Has any member of Insured'sfamily or any person in his immediate household ever been afflicted similarly? if so, who?

_____

_____

Additional Remarks:

_____

_____

_____

(Signature of Witness)

Residence (No.) (Street) (City) (State)

_____

Dated (Month) _____ (Day) _____ (Year) _____

If heart is involved, what laboratory tests have been made?

Pulse _____ Irregular _____

Blood pressure S _____ D _____

_____ M.D.

(Signature of Physician)

Residence (No.) (Street) (City) (State)

_____

Dated (Month) _____ (Day) _____ (Year) _____

Statement No. 2

Commercial register no. 3623 on 13 July 1953 and registered in the register of insurance companies Sub. No. 30 on 29 November 1956, Governed by the insurance regulation law Decree no. 9812 as of May 1968 4 and its amendments.
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