MetLife®

RECOVERY BENEFIT PLAN / CRITICAL ILLNESS FORM

POLICY NO. _____

PART A - INSURED'S STATEMENT

Name of Insured _____

Insured's Address: _____

Street _____ P.O.Box _____

City _____ Country _____

==========

1. Nature of Disease _____

2. Date of First Consultation _____

3. Date of Diagnosis of Disease _____

4. Has disease been caused by:
   a. Acquired Immune Deficiency (AIDS)? _____
   b. Misuse of drugs or alcool ? _____

5. Cardiac Bypass Surgery (if applicable)
   a. Date of Surgery _____
   b. No. of Coronary Arteries involved _____

6. a. Name of Treating Physician _____
   b. Physician's address _____

_____

_____

==========

AUTHORIZATION

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of their records) regarding myself, my medical history in general and this claim in particular to ALICO, **AMERICAN LIFE INSURANCE COMPANY**.

A photocopy of this authorization shall be considered as original.

Signature of Insured _____ Date _____

American Life Insurance Company is a MetLife, Inc. Company
Registered in the Register of Insurance Cos. Sub. No. 30 on 29 Nov, 1956. Governed by Decree No. 9812 of May 4, 1968. Amended by Law No. 94 of 28 June, 1999

MetLife Dec. 2015 RBP CI - 42 - EC 28122015

PART B - PHYSICIAN'S STATEMENT

Name of Patient_____ Date of Birth_____

Height _____ Weight _____

==========

1- COMPLETE FOR MYOCARDIAL INFARCTION

a. Final diagnosis _____

_____

b. Date of Diagnosis _____

c. Was there history of Chest Pain ? Yes _____ No _____
If yes, give details.

_____

d. Did EKG reveal new Electrocardiographic changes ? Yes _____ No _____
If yes, give details.

_____

e. Was there elevation of Cardiac Enzymes ? Yes _____ No _____
(Company requires all laboratory test, EKG and X-RAYS done)

2- COMPLETE FOR CORONARY ARTERY DISEASE REQUIRING SURGERY

a. Date of Diagnosis _____

b. Nature of Surgery _____

_____

c. Date of Surgery _____

d. No. of Coronary Arteries involved _____
(Company requires all laboratory Test, EKGs and Catheterization Film & Diagram)

3- COMPLETE FOR CEREBRAL STROKE

a. Final Diagnosis _____

_____

b. Date of Diagnosis _____

c. Did EEG reveal permanent neurological deficit? _____
(Company requires all laboratory Test, EEGs and Neurologist Opinion Confirming diagnosis)

4 - COMPLETE FOR CANCER

a. Detailed final diagnosis including location _____

_____

_____

b. Date of Diagnosis _____

c. Medical History _____

_____

(Company requires all laboratory and Tissue Biopsy Pathology Tests)

5 - COMPLETE FOR CHRONIC, IRREVERSIBLE RENAL FAILURE

a. Detailed diagnosis _____

_____

_____

b. Date of Diagnosis _____

c. Medical History _____

_____

d. Natre of Treatment _____

(Company requires all laboratory Tests)

6 - COMPLETE FOR BLINDNESS CAUSED BY SICKNESS

a. Nature of Sickness _____

_____

b. Is blindness total, permanent and irrevocable ? Yes _____ No _____

_____

c. Date of Diagnosis _____

d. Medical History _____

_____

COMPLETE FOR DIAGNOSED DISEASE

1. Date you were first consulted for the symptoms of his condition:

Month : _____ Day : _____ Year : _____

2. Date patient had previous medical attention for this condition :

Month : _____ Day : _____ Year : _____

Physician _____

Address : Street _____ City _____

3. Dates confined to Hospital :

From : _____ To : _____

From : _____ To : _____

4. Hospital Name _____

Address _____

5. Has disease been caused by : (Give Details)

a. Acquired Immune Deficiency Disease Virus (HIV) , or is it an AIDS related complex of infection by HIV Virus?

_____

_____

b. Misuse of Drugs or Alcohol ?

_____

_____

Name of Attending Physician _____

Hospital or clinic address _____

Signature _____ Date : _____