MetLife

MEDICAL CLAIM FORM

A. GROUP POLICY Name & No. _____

B. EMPLOYEE'S SECTION

1. Employee's Name & Date of Birth: _____
2. Patient's Name & Date of Birth: _____
3. Individual Certificate No.: _____
4. Patient's Effective Date of Coverage: _____
5. Nature & Date of Sickness / Accident: _____
6. Physician's / Surgeon's Tel. No. & Complete Mailing Address _____
7. Total amount claimed _____
8. Is this claim arising out of the patient's occupation? _____

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and / or any of my family members 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 taken as the original copy.

Employee's Signature: _____ Date: ____/____/____

Employer's Signature & Stamp: _____

C. ATTENDING PHYSICIAN'S SECTION

1. Diagnosis (Block Letters): _____
2. Date Symptoms first appeared: _____
3. If the claim is resulting from pregnancy / Childbirth, please provide date of LMP _____
4. Dates of current treatment Out-Patient _____
   In-Patient _____
5. Details of treatment (other than prescription) _____
6. Dates of previous treatment Along with name of treating physician: _____
7. Is further treatment or operative procedure anticipated If «Yes», please provide full details and expected dates Yes ☐ No ☐

Physician's / Surgeon's Signature & Stamp: _____ 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
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