MetLife®

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 Weight _____feet _____Inches _____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? (Month) (Day) (Year)
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 affliction 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 _____ Signature of Insured _____

day of _____ 20_____ Residence _____
No. Street City

_____ _____
Notary Public State

STATEMENT No. 1

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AMERICAN LIFE INSURANCE COMPANY

ATTENDING PHYSICIAN'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 Insured.	2. Where is Insured now located? (If an inmate of a hospital or other institution give name and address).
3. How long have you been Insured'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) If 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 Insured 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 From	To	c. Name of physician or Practitioners	d. Address

11. Has Insured ever received treatment for specific disease? If so, give particulars.	
12. Has any member of Insured's family or any person in his immediate household ever been afflicted similarly? If so, who?	
Additional Remarks:	If heart is involved, what laboratory tests have been made? Pulse _____ Irregular _____ Blood pressure S _____ D _____

_____ M.D.

(Signature of Witness) (Signature of Physician)

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

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

CL - 41

STATEMENT NO. 2

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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