MetLife

PROOF OF DEATH – STATEMENT OF BENEFICIARY

1. FULL NAME OF MAIN INSURED: (IF FEMALE GIVE THE MAIDEN NAME AS WELL)	
2. POLICY NUMBER:	3. AMOUNT OF CLAIM:
4. DATE OF BIRTH OF MAIN INSURED:	5. PLACE OF BIRTH OF MAIN INSURED:
6. HOME ADDRESS OF MAIN INSURED:	
7. NAME AND ADDRESS OF THE LAST EMPLOYER:	
8. DATE OF DEATH:	9. PLACE OF DEATH:
10. DESCRIPTION OF CAUSE OF DEATH:	
11. START DATE OF LAST ILLNESS:	
12. DETAILS OF DOCTORS WHO EXAMINED THE MAIN INSURED DURING THE TIME OF THE LAST ILLNESS,AS WELL AS THE DOCTORS WHO EXAMINED THE MAIN INSURED PRIOR TO THE LAST ILLNESS, FOR THE LAST THREE MONTHS :	FULL NAME ADDRESS PHONE NUMBER ....
13. CONFIRM THE EFFECTIVE DATES, COVERAGE AMOUNTS AND NAMES OF OTHER INSURANCE COMPANIES WHERE THE MAIN INSURED HAD OTHER INSURANCE CONTRACTS:	COMAPANY AMOUNT EFFECTIVE DATE ....
14.FULL NAME AND ID NUMBERS OF THE ADMINISTRATORS:	
15.NAME AND ID NUMBER OF POLICY OWNER:	

The undersigned signatories, with the current submission of claim related to above mentioned insurance, accept the documentation statement and/or sworn testimonies of everyone including the doctors, who followed or prescribed therapy to the main insured, as well as all of the general documents that are requested according to the company's policy provision, result and establish towards the proof of death. Furthermore, I accept that the benefits from the company of the current form or any other form for completion do not result nor imply that the existing insurance is in force towards the life of the above insured, neither is considered as the resignation of the company from any of their entitlements.

I authorize all of the Organizations as well as all of the doctors, the diagnostic centers and the laboratories that the deceased visited, to provide to MetLife and to every authorized person, all of the information regarding of his medical record regarding his medical history, the results of tests done from doctors or diagnostic centers, the diagnosis and the therapies. In addition, I consent to the handling of the claim, based on the provisions under clause 138(1)2001, of personal protection data Law, for the purpose of evaluation of the claim submitted.

DATE: ..... ADMINISTRATORS: 1.....
2. .....

WITNESS: ..... POLICY OWNER: .....

WITNESS: ..... POLICYHOLDER: ……

WITNESS: ..... ASSIGNEES: ……

This form should be witnessed by the employer for Group Policies. For other cases, the director of the branch office or a certified employee should sign as a witness.

CL 1