MetLife

NOTIFICATION OF CLAIM

POLICY NUMBER: ..... DATE OF BIRTH: .....

NAME OF INSURED ..... ID NUMBER: .....

NAME OF DEPENDANT: ..... DATE OF BIRTH .....

1. HOME ADDRESS: ..... TEL .....

2. EMPLOYER, WORK ADDRESS: ..... TEL. .....

3. OCCUPATION : .....

4. EXACT DUTIES PERFORMED: .....

5a DATE OF ACCIDENT: ..... TIME OF ACCIDENT: .....

5b DATE ILLNESS INCURRED:.....

6. WHEN AND HOW DID THE ACCIDENT OCCUR (DETAILED ACCOUNT): .....

.....

7. LOCATION AT TIME OF ACCIDENT (NAME AND ADDRESS) .....

.....

8. ATTENDING PHYSICIANS AND DATES OF VISITS: .....

9. DESCRIPTION OF INJURY: .....

10. DESCRIPTION OF ILLNESS: .....

11. EXACT DATE OF COMMENCEMENT OF ABSENCE FROM WORK AS A RESULT OF INJURY OR ILLNESS :.....

.....

12. DATES OF HOSPITALIZATION: FROM: ..... UNTIL: .....

13. POSSIBLE DATE FOR RETURNING TO WORK: .....

14. PREVIOUS CLAIMS/ REIMBURSEMENTS: .....

DECLARED BY: ..... DATE: ..... SIGNATURE: .....

AGENCY MANAGER'S COMMENTS

.....

.....

SIGNATURE : .....DATE:.....

FOR INTERNAL USE ONLY

.....

.....

THE POLICY'S PAID TO DATE: .....DATE OF LAST PAYMENT:.....

AGENT AND AGENT CODE .....

BENEFITS	RESERVE AMOUNT	BENEFITS	RESERVE AMOUNT	BENEFITS	RESERVE AMOUNT
.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....