MetLife®

CLAIMANTS STATEMENT
FOR SICKNESS, HOSPITILIZATION OR SURGERY

Policy Number: …….. Identity Card No. ……..……

Full name of Patient : ……..……

Full name of Insured : …….. Date of Birth : …….

Address : ……..…… Telephone : ……

Occupation : ……..

Disease / Surgery :…….. ……..…….....

Describe the Symptoms : ……..……..……

When did symptoms first appeared; (exact date);…….. ……..…….....

……

Have you ever had the same or similar symptoms in the past; NAI ☐ OXI ☐

If yes, give details…… ……..……

……

Give us below the details of the all the doctors who examined you for this disease:

Doctors Name

1. ……..…….. Date. : …… Tel.: ……..

2. ……..…….. Date. : …… Tel.: ……..

3. ……..…….. Date : …… Tel.: ……..

What examinations has the doctor recommended or performed;

……..……..

……

Present state of Health: ……..……..

……

Hospitalization Dates : Admission Date : ……..……. Discharge Date ..……

Name of Hospital or Clinic : ……..……..……..

DECLARATION/AUTHORIZATION

I hereby declare to the best of my knowledge that all the information on the form is true and correct. During the process of my claim I hereby agree to provide MetLife Insurance Company, the results of my medical examinations, the diagnostic tests and treatment to be reviewed by doctors cooperating with the Insurance Company, adhere to 138(1)2001 law, and as amended, only for the medical information that is directly related and essential for the purpose of examining my claim if the insurance company considers it to be absolutely necessary to decide whether my claim is considered payable based on my policy provisions and or to define the extend of my reimbursement.

Insured signature : …….. Date: ……