MetLife®

DESCRIPTION OF OCCUPATIONAL DUTIES

NAME OF INSURED:
CLAIM NUMBER **POLICY NUMBER**
Date of Commencement of illness or accident occured:
Occupation immediately prior to disability (if more than one, please state them all)

List of all duties performed by you at your current workplace

Duty performed	**Number of hours spent on task per week**

Describe the physical demands your job entails:

State which of the above duties you are no longer able to perform and why:

State any previous work experience and educational background:
State what tasks you can perform or would be able to perform

Please state anything else that may influence your claim:

DECLARATION: I hereby declare that the above answers are true and correct and authorize the doctors who have examined me to provide METLIFE all information regarding my medical history and any other information they might request.

Signature of Insured..... Date.....

Witness..... Date.....