APPLICATION FOR INSURANCE

Agent's Code no. ☐☐☐☐☐☐☐☐☐

Agency/Unit/Entity Name ....

Agent's Name. ....

Agent License No. 16/.......... Renewed on ....

☐ Medical ☐ Non-Medical

AMERICAN LIFE INSURANCE COMPANY
(Incorporated in USA, Nepal
Regn. No. 6/062/063
Narayani Complex, Pulchowk
G.P.O. Box: 11590, Kathmandu, Nepal
Phone No.: +977-1-5555166,
Fax : +977-1-5555173
Toll Free No.: 1660-01-55555

PP Size photo of Applicant

A. PERSONAL DETAILS

1. a. Name of proposed insured/applicant as shown in Identification Document.

In English W R I T E I N B L O C K L E T T E R S

In Nepali

b. Place of birth: .... Date of birth: D D M M Y Y Y Y Age: ☐☐ Year

c. Gender: ☐ Male ☐ Female

d. Marital Status: ☐ Single ☐ Married ☐ Widowed/Widower ☐ Divorced/Separated

e. Father's Name: .... f. Mother's Name: ....

g. Spouse's Name: .... h. Nationality: ....

2. a. Occupation: ☐ Employee ☐ Self Employed ☐ Other (Please Specify) ....

Position/Title: ....

State Exact Daily Duties: ....

b. Employer/Business Name : ....

c. Current Office/Business Address : ....

Phone No.: .... Email ID: ....

d. PAN No.: ....

e. Bank Account No.: .... Bank Name: ....

3. Average Monthly income : ....

Other Source(s) of Income : ....

4. Permanent Address :

House No: .... Village/ Tole: .... Ward No.: ....

Gaupalika/Nagarpalika/Sub-Metropolitan/Metropolitan: .... District: ....

State: .... Country: .... G.P.O. Box No.: .... Tel.: .... Mobile No: ....

5. Residential Address (If other than permanent address):

House No: .... Village/ Tole: .... Ward No.: ....

Gaupalika/Nagarpalika/Sub-Metropolitan/Metropolitan: .... District: ....

State: .... Country: .... G.P.O. Box No.: .... Tel.: ....

(If there is a change in my mailing address and / or contact number, I will notify the company in writing as soon as possible.)

6. Details of Juvenile insured or payor (If different from applicant):

Full Name (in Nepali): .... Full Name (in Engish) : ....

Relationship to Applicant: ....

Address if different than applicant: ....

....

Father's Name: .... Mother's Name: ....

Date of birth: D D M M Y Y Y Y Age: ☐☐ Year/Month Gender ☐ Male ☐ Female

Place of Birth: .... Nationality: ....

Insurance Detail: ....

....

PP Size photo of Child/Payer

B. DETAILS OF BENEFICIARY (IES)

Full Name, address and contact No.	Relationship with insured	Nationality	Name of Mother and Father of Beneficiary
....	....	....	....
....	....	....	....
....	....	....	....
....	....	....	....

Unless otherwise stated, multiple beneficiaries will share equally, and the right to change the beneficiary is reserved.

Note : To expedite the approval of applied insurance coverage, before submission, please ensure that the application is properly completed, signed and dated. Please inform to the company if the policy for this application is not received within 30 days from the date of premium payment.

C. DETAILS OF LIFE INSURANCE APPLIED FOR: (Only if application is approved, a life insurance policy will be issued)

Ordinary and Universal Life

Insurance Plan ....
Term ....
Coverage Amount (Rs) ....
Amount in Words ....
....

Select riders and state rider coverage amount

- ☐ Accidental Death, Dismemberment and Permanent Total Disability (PA-AD,D&PTD) ....
- ☐ Critical Illness (CI)
- ☐ Family Protection Rider (FPR)
- ☐ Waiver of Premium (WP)
- ☐ Disability Protection Rider (DPR)
- ☐ Accidental Death Benefit (ADB)
- ☐ Life Time Income (LTI)
- ☐ Others ....

Non-forfeiture options for the endowment plans:

☐ Automatic Premium Loan ☐ Paid Up

Mode of Premium Payment

☐ Annual ☐ Semi-annual ☐ Quarterly ....

Total Premium (Rs) ....

Life Care

Term ....

State benefits coverage amount below

Loss of life Coverage (Rs) ....
Benefit Plan 1 (Life Care Beautiful) Coverage (Rs) ....
Benefit Plan 2 (Life Care Brave) Coverage (Rs) ....

Mode of Premium Payment

☐ Annual ☐ Semi-annual
☐ Quarterly ....

Total Premium (Rs) ....

Life Shield

Occupation Class ....
Package ....
☐ Executive Plan
☐ Executive Gold Plan

State benefits coverage amount below

Loss of Life (Rs) ....
(AD,D&PTD) Lumpsum (Rs) ....
(AD,D &PTD Life Time Income (Rs) ....
In-Hospital Income due to Accident (IH-A) (Rs) ....
In-Hospital Income due to Accident and Sickness (IH-A&S) (Rs) ....
Accidental Disability Income 52 weeks (AWI) (Rs) ....
Accident & Sickness Surgical (A&S) (Rs) ....
Accidental Medical Expenses Reimbursement (AMR) (Rs) ....

Mode of Premium Payment

☐ Annual ☐ Semi-annual ....
☐ Single Premium Payment

Total Premium (Rs) ....

D. EXISTING AND APPLIED INSURANCE DETAILS

1. Existing and /OR Applied (other than this) insurance detils of Proposed Insured and Applicant

Policy no.	Company	Life Insurance Amount	PA Amount	Annual Premium
....	....	....	....	....
....	....	....	....	....
....	....	....	....	....

2. If Insured is minor, provide (a) number of siblings .... and
(b) Details of insurance

Relationship with insured	Policy no.	Company	Life Insurance Amount	PA Amount	Annual Premium
....	....	....	....	....	....
....	....	....	....	....	....
....	....	....	....	....	....

SECTION E, F & G PERTAIN TO ALL PROPOSED INSURED NAMED IN THIS APPLICATION

E. DETAILS PART ONE (This Section is required for all products)

E. DETAILS PART ONE (This Section is required for all products)	Mandatory for Juvenile insured
1. Proposed Insured's/Applicant Height .... ft .... inch/.......... cm	Proposed Child's Height .... ft .... inch/.......... cm
Proposed insured's/Applicant Weight.......... kgs/ .... lbs	Proposed Child's Weight .... kgs/ .... lbs

	Yes	No
2. Have you or any of the proposed insured ever had indication of, diagnosis of, treatment or surgery for?		
a. Rheumatic fever, high blood pressure, chest pain, heart attack or any disorder of heart, blood or blood vessels?	☐	☐
b. Any form of cancer, tumor or cyst?	☐	☐
c. Diabetes, high blood sugar, thyroid disorder or any endocrine disorder?	☐	☐
d. Hepatitis or any other liver disorder, stomach or intestines?	☐	☐
e. Any kidney, urinary or reproductive disorder?	☐	☐
f. Stroke, epilepsy, paralysis or any other nervous disorder?	☐	☐
g. Asthma, tuberculosis, respiratory or lung disease?	☐	☐
h. Mental or psychiatric illness including anxiety and depression?	☐	☐
i. Any disease or disorder of the muscles spin, joints and limbs including loss of feeling or tremor?	☐	☐
j. Any chronic condition, infirmity, any form of eye, hearing or speech disorder or disease or injury not mentioned above?	☐	☐
3. Have you or any of the proposed insured had other than stated above, any medical or surgical treatment, or investigative medical tests or hospitalizations or have you been advised to undergo any diagnostic tests, hospitalization or surgery which was not done?	☐	☐

4. Have you or any of the proposed insured ever consulted or been treated for HIV/AIDS, HIV/AIDS Related complex, or sexually transmitted disease or been told you or any of the proposed insured have any of these or that you or any of the proposed insured had tested positive for HIV/AIDS (please state reason and results)/or have you or any of the proposed insured had unexplained fatigue, weight loss, diarrhoea, or unusual skin lesions ? Yes ☐ No ☐

5. Has any member of your immediate family ever suffered or died from any of the above stated conditions? If Yes, please provide details below: ☐ ☐

Family Members	Age	Health Status/Cause of Death	Age at time of diagnosis	Age at Death

6. Are you now a member of any military force, or do you now or intend to undertake or participate in any kind of racing, scuba or sky diving, hang gliding, parachuting, private flying, mountaineering, rock climbing, auto cycle or boat racing, surfing or skiing on land or water etc. or any other hazardous sport or activity, or do you fly or intend to fly other than as a fare-paying passenger on regularly scheduled airlines ? If yes, give details: ....
....
.... ☐ ☐

F. DETAILS PART TWO (This section is not required for Life Shield)

Yes No

1. Have you or any of the proposed insured smoked cigarettes, or any other form of tobacco within the past 12 months ?
   If yes, state how many/much per day. Type .... Quantity ..../day ☐ ☐
2. Have you ever been treated for or had any complication as a result of alcohol use or do you currently drink alcohol?
   If yes, please state: Amount .... Per day/week. ☐ ☐
3. Name and address of personal physician or family doctor if any...
   .... ☐ ☐
4. **Female only**
   a. Are you or any of the proposed insured now pregnant? If yes, how many months ? _____________ ☐ ☐

If details to above questions in section E and F is "Yes", please include name of the proposed insured, dates, names of doctors, hospitals, reasons for consultation, tests, results, diagnosis, treatments and current condition.

Question No.	Name	Date	Reason for consultation, test results, treatment and current condition	Name of doctors, hospitals, and address

Special request or additional information, if any, please mention: ....
....

G. GENERAL QUESTIONS (This section is not required for Life Shield)

Yes No

1. I. Are you or any of the proposed insured a resident or a citizen or green card holder of United States of America? ☐ ☐
   If yes, please state US Tax ID Number ....
   II. Is the beneficiary(ies) a resident or a citizen or green card holder of United States of America?
   If yes, please state US Tax ID Number .... ☐ ☐
2. Has any application for or reinstatement of life, Accident or Health Insurance ever been declined, postponed, rated or in any way modified ? If yes, give details: .... ☐ ☐
3. Do you plan to live or travel outside your current country of residence within the next 12 months ? If yes , name country(ies), purpose and length of stay, details in space provided below. ☐ ☐

Country	Approximate Date of Travel	Reason	Length of Stay
....	....	....	....
....	....	....	....

DECLARATION

(a)I hereby declare that I and proposed insured are in good health and agree that there shall be no contract of insurance unless a policy is issued and delivered on this application and full force premium actually paid. **(b)** I hereby declare that all statements and answers in this application together with those in any required medical examinations, questionnaires or amendments are full, complete and true and bind all parties in interest under the policy herein applied for.**(c)** I understand that no agent or medical examiner or other person except authorized officer of the company is permitted to make or discharge contracts or waive or change any of the conditions or provisions of any application, policy, or receipt, or to accept risk or pass upon insurability; that notice to or knowledge of any agent or medical examiner is not notice to or knowledge of the company unless stated in either this application or medical examinations considered as part of it.**(d)** I understand that no right to borrow, surrender or assign or other privilege of ownership may be exercised by a minor; and that acceptance of any policy issued on this application shall be a ratification of any correction or changes to this application.**(e)** I hereby exonerate any Physician and/or Hospital and/or Clinic and/or Insurance Company and/or other Organization that has any records or knowledge of me and/or proposed insured(if any) from professional secrecy and hereby authorize such person and/or entities to give to American Life Insurance Company any and all information about me and/or proposed insured and copy of records with reference to our health and/or medical history and/ or hospitalization, medical diagnosis, treatment, disease and/or ailment.**(f)** (i) I understand that under the Individual Privacy Act 2018, American Life Insurance Company, Nepal (MetLife) is authorized to collect, store, protect, analyze and process my personal information, Data and Sensitive information including information concerning my financial and/or professional and/or personal status, as well as information related to my driving license, history related with health, (collectively personal information) to conduct insurance business and further understand that MetLife is committed to respecting privacy in the management of the Personal Information so collected and the adopting appropriate security measures to preserve it in a confidential manner. (ii) I hereby authorize MetLife to obtain/collect my Personal Information from me or any national or foreign, public or private source, if deemed necessary. (iii) I understand and confirm that my Personal Information collected and held by MetLife may be used for any present or future contractual or other commitment with any legal, regulatory, governmental, tax, law enforcement or other authorities or self-regulatory or industry bodies or associations of financial services providers that is assumed by or imposed on MetLife by reason of its financial, commercial, business or other interests or activities in or related to the jurisdiction of the relevant legal, regulatory, governmental, tax, law enforcement, or other authorities or self-regulatory or industry bodies or associations including its parents, subsidiary and related companies (whether within or outside Nepal). (iv) I also give consent to store my Personal Information digitally in a secured server/cloud base and to any necessary cross border data transfers. I also give consent to disclose said business maintenance and development purposes. (v) If I have any questions concerning the Privacy Policy, I will contact Metlife offices in Nepal and /or visit MetLife's website metlife.com.np. **(g)** I authorize MetLife to investigate or cause to be investigated my financial, administrative and criminal background to comply with the Anti-Money Laundering laws and regulations as required. **(h)** I also declare that, I have personally gone through/ read the text of the authorization and fully understood it's content before putting my signature. **(i)** I understand and agree that no coverage will be in effect until the application is approved by the company and that the policy will only cover injury, disease or illness that originates after the date of first premium payment.

Important Notice :

1. Any change in occupation or health condition of the proposed Insured(s) and in any of the declaration made in the application, after the date of application and before the issuance of first premium receipt, must immediately be notified to the company. Failure to such notification will invalidate the policy and the invalidated policy will not make Company liable to pay any future claim or refund of premium.
2. Please obtain premium receipt after premium payment
3. While paying premium through cheque, please draw cheque in favour of American Life Insurance Company.

....

Name of Proposed insured/applicant in own handwriting

Thumb Print

Right	Left

....

Signature

....

Name of payor if other than proposed insured/applicant

Thumb Print

Right	Left

....

Signature

Witness Name :...

Signature : ....

Address: ....

....

Signed at :

....

Village/City and District

Date : ....

If the above answers are given by a person who cannot understand language of application or who is illiterate or who cannot read & write due to some other reasons, a declaration has to be made by a family member of the applicant and/or by a well-known person not related to the Company, who read, explained and/or filled up application form :

I declare that I have well explained the subject matter of the application to the above applicant and all answers have been recorded correctly and the proposed insured has affixed the thumb print after having been well understood.

Dated at: .... Date ....

Full Name: ....

Occupation: ....

Full Address : ....

....

Signature

MetLife

AGENT'S REPORT

'(This Section is Not Required for Life Shield)'

Prosposed insured/applicant's name: ....

1. How long and how well have you known applicant and /or proposed insured? .... Well ☐ Casually ☐ Just met ☐

2. Give relationship if related to proposed insured or owner ....

3. Has proposed insured surrendered or closed any insurance policy currently? ☐ Yes ☐ No

4. Does the proposed insured and/or applicant have any application for Life, Accident or Health Insurance now pending? ☐ Yes ☐ No

5. Do you have any knowledge of any unfavorable information about the health, illness, treatment, habits, physical condition,family history, character, mode of life or occupation of the proposed Insured and /or applicant. ☐ Yes ☐ No

   Give details, If "Yes" ....

   ....

6. Give details here, if any of the answers to above questions no 3, 4 and 5 is "Yes"

   ....

   ....

I hereby certify that the answers to the questions in this Application and Report are correct to the best of my knowledge and belief that know nothing detrimental to the risk that is not recorded herein.

Signed at .... (Village/City & District) on the date of ....

Full Name of Agent .... Agent Code No. ....

Signature...

I have carefully checked the answers in the above report and in Application form with the Agent(s) and I am satisfied that they present an accurate picture of the Proposed Insured(s) and the Applicant.

....

Signature of Unit Manager Signature of Agency Manager

* Please Check if supplementary information is required on accounts of sum insured.

Premium Calculation

Basic Plan	Face Amount	Mode of Premium Payment ....
Basic Premium ______________________________	Rs.______________________________	Rs.______________________________
Policy Factor	Rs.	Rs. ....
Extra Premium	Rs.	Rs. ....
CI	Rs.	Rs. ....
FPR/WP	Rs.	Rs. ....
ADB	Rs.	Rs. ....
PA	Rs.	Rs. ....
DPR	Rs.	Rs. ....
Other(s)	Rs.	Rs. ....
	Total	Rs. ....

CLEAR

Submit This Form