APPLICATION FOR LIFE AND PERSONAL ACCIDENT INSURANCE

APP. No.

Agent's Code No.

Agency's/Unit's Name .....

Agent's Name .....

Agent Licence No. 16/ ..... Renewed on .....

☐ Medical ☐ Non-Medical

MetLife

American Life Insurance Company

(Incorporated in 1868 in the U.S.A. and Registered for Life Insurance Business in Nepal under Insurance Act, 2049) Company Regn. No. 6/062/063)

NEPAL OFFICE:
Narayani Complex, Pulchowk, G.P.O. Box No. 11590, Kathmandu, Nepal.

P.P. Size Photo of Proposed Insured

Please inform to the company if the policy for this application is not received within 30 days from the date of premium payment.

A. PERSONAL DETAILS (Please write in Block)

1.a) Name of Proposed Insured (shown in Identification Document)

English

Nepali

b) Type of Identification Document .....
Citizenship/Passport No. .....

c) Place of Birth .....

Date of Birth: D D M M Y Y Y Y Age Last Birthday

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed/Widower ☐ Divorced/Separated

Father's Name: .....
Mother's Name: .....
Husband/Wife's Name: .....
Nationality: .....

2. Applicant/Owner (if other than insured)

Full Name: .....
Relationship to insured: .....
Current Residence Address: .....
.....
Insurance detail: .....

Photo of Applicant/ Owner

3. a. Occupation: ☐ Employee ☐ Self-employed

Position / Title: ..... Education: .....

State Exact Daily Duties: .....

b. Employer/Business Registered Name: .....

c. Nature of Business: .....

d. Current office/Business Address: .....

Phone No. ..... Fax No. .....

e. Permanent Account Number: .....

4. Average Monthly Income in the past 12 months: .....

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

5. Permanent Address: House No. ..... Village/Tole .....
Ward No. ..... V.D.C. / Municipality .....
District ..... Country ..... Tel.: .....

6. Current Residence Address: House No. .....
Village/Tole ..... Ward No. .....
V.D.C. / Municipality .....
District ..... Country .....
Tel: ..... Mobile No.: .....
E-mail : .....

Send Correspondence to : ☐ Residence ☐ Office
Other .....

B. DETAILS OF LIFE INSURANCE APPLIED FOR:

If approved, a life policy will be issued

1. Plan of Insurance ..... (State in full words)	2. Amount of Insurance in words (in Rupees)	3. Mode of Premium Payment

4. Supplementary Contracts: ☐ WP ☐ ADB ..... ☐ PA - (AD, D & PTD) Principle sum Rs..... ☐ Others .....

5. Non-Forfeiture Options (Applicable, incase premium becomes due after expiry of grace period): (This provision is not applicable to Future Care-DPS Plan)

☐ Automatic Premium ☐ Paid Up ☐ ETI (For Three Payment & Endorsement Plan only)

6. Payment Options (for Subhabishya Beema):

☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☐ Option 5

C. NAME & ADDRESS OF BENEFICIARY FOR LIFE (and for PA, if applied for)

	Relationship with insured	Age	Name of Mother & Father of Beneficiary
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

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

Note: To expedite the approval of applied for insurance coverage, before submission, Please insure that the application is properly completed, signed and dated.

D. EXISTING and/or APPLIED (Other than this) INSURANCE DETAILS:

Policy No.	Company	Life insurance amount	PA Amount	Annual Premium

E. QUESTIONS PERTAIN TO ALL PROPOSED INSURED NAMED IN THIS APPLICATION :

I. General (To be completed for all Proposed Insureds)

	Yes	No
1. 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:	☐	☐
2. 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 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:	☐	☐

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

II. Health Details (To be completed for all Proposed Insureds)

1. Name and address of personal physician or family doctor if any .....
..... Date last seen:..... Reason .....
Advice given:.....

	Yes	No
2. Proposed Insured's Height: ..... ☐ cm ☐ ft Weight:..... ☐ kgs ☐ lbs		
3. Have you smoked cigarettes, or any other form of tobacco or taken alcohol within the past 12 months? If yes, state how many/much per day. Type ..... Quantity ..... /day	☐	☐
4. Have you had 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?	☐	☐
5. Have you 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. Any form of blood disorder or disease ?	☐	☐
h. Asthma, tuberculosis, respiratory or lung disease ?	☐	☐
i. Mental or psychiatric illness including anxiety and depression ?	☐	☐
j. Any disease or disorder of the muscles spin, joints and limbs including loss of feeling or tremor ?	☐	☐
k. Excessive consumpation of alcohol, alcoholism and drug abuse ?	☐	☐
l. Any chronic conditon, infirmity, any form of eye, hearing or speech disorder or disease or injury not mentioned above ?	☐	☐
6. Have you ever consulted or been treated for AIDS, AIDS Related Complex, or sexually transmitted disease or been told you have any of these or that you had tested positive for AIDS (please state reason and results) / or have you had unexplained fatigue, weight loss, diarrhoea, or unusual skin lesions ?	☐	☐
7. Has any member of your immediate family ever suffered or died from any of the conditions stated above ?	☐	☐

Family Members	Age	Health status / Cause of death	Age at time of diagnosis	Age at Death

8. Female Only:

	Yes	No
a. Have you ever had a Pap smear which you were advised to repeat within 6 months or was found to be abnormal ?	☐	☐
b. Are you now pregnant ? If yes, how many months ? _____	☐	☐
c. Have you ever had miscarrage/abortion or other complication at childbirth or disorder of the breast or female organs?	☐	☐

d. Name of the husband: _____ Occupation _____
e. Inforce insurance on husband: _____ Company Name: _____
f. Number of children: _____ Ages: _____

Details to any "Yes" answers to above questions in section E, I & II include name of proposed insured, dates, names of doctors, hospitals, reason for consultation, tests, results, diagnosis, treatments and current condition.

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

Special Request:	Company Endorsement Only :

DECLARATION:

(a) I hereby declare that I and my family members proposed for insurance 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 first premium actually paid thereon provided no change shall have occurred in the insurability of the Proposed Insured(s) since completion of the application. **(b)** I hereby declare that all statements and answers in this application together with those in any required medical examination, questionnaire 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 an 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 risks 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 any medical examination 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 which the company may make in the space entitled "Company Endorsement Only." **(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 my family members proposed for insurance (if any) from professional secrecy and hereby authorize such person and/or entities to give to American Life Insurance Company (ALICO) any and all information about me and/or my family member proposed for insurance and copy of records with reference to our health and/or medical history and/or hospitalization, medical advice, diagnosis, treatment, disease and/or ailment. **(f)** I also authorize American Life Insurance Company (ALICO) to obtain, from any source it deems appropriate, information concerning my financial and/or professional and/or personal status, as well as information related to my driving history. A photocopy of this authorization shall be as valid as the original. **(g)** I also declare that, I have personally gone through/read the text of the application and fully understood it's content before putting my signature.

Important Notice:

- **Before signing this declaration please check that the answers given in this application are completed and correct. An incorrect or incomplete answer may invalidate the policy and the invalidated policy will not make the Company liable to pay any future claim or refund of premium.**
- **Any change in occupation or health condition of the proposed Insured(s) and in any of the declartion 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.**
- **The premium paid after approval of application shall not be refunded under any circumstances except under the provisions of the policy.**
- **Please obtain premium receipt signed by authorized employee of the company after paying premium as there shall be no insurace coverage until premium receipt for LIfe Insurance is issued by the company.**
- **Please pay premium by account payee cheque/draft drawn in favour of the company.**

Dated at: ..... (Village/City & District) this ..... day of ..... (Date) 201.....

.....
Name of Proposed Insured in own Handwriting

Witness Name: ..... Signature .....

.....
Signature of Proposed Insured

Address/Code No. .....

.....
Name and Signature of Owner if other than Proposed Insured

If the above answers are given by a person who can not understand language of application or who is illiterate or who can not 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 applicant and all answers have been recorded correctly and the proposed insured has affixed the thumb print after having been well understood.

Date at ..... (Village/City & District) this ..... day of ..... (Date) 201 .....

Full Name: .....

Occupation: .....

.....
Signature

Full Address: .....

.....

AGENT'S REPORT

MetLife

American Life Insurance Company
(Incorporated in 1868 in the U.S.A. and Registered for Life Insurance Business in Nepal under Insurance Act, 2049) Company Regn. No. 6/062/063)

NEPAL OFFICE:
Narayani Complex, Pulchowk, G.P.O. Box No. 11590
Kathmandu, Nepal.

Application No.:.....

Name of Proposed Insured.....

How well do you know	Well	Casually	Just met
1. PROPOSED INSURED?	☐	☐	☐
OWNER?	☐	☐	☐

2. Give relationship if related to Proposed Insured or Owner
.....
3. What is ANNUAL EARNED income of
PROPOSED INSURED .....
OWNER .....
4. Specify Accident insurance on the Life of PROPOSED INSURED:
Accidental Death Benefit .....
Weekly income .....
5. Is this insurance applied for intended to replace existing coverage ? ☐ Yes ☐ No
6. Does the PROPOSED INSURED have any application for Life, Accident or Health Insurance now pending ? ☐ Yes ☐ No
7. Do you have knowledge of any unfavourable information about the health, habits, character, mode of life or occupation of the ProposedInsured or Owner. Give details, if "Yes" ☐ Yes ☐ No
8. REMARKS AND ADDITIONAL INFORMATION
.....
.....
.....

IF PROPOSED INSURED IS A FEMALE

9. With whom does she reside ?.....
10. Source of her support .....
11. Education Standard/Level.....
12. Name and relationship of any dependents. .....
.....
13 . Give ages of any children:.....

IF MARRIED

14. Her maiden name:.....
15. Husband's full name: .....
.....
16. Husband's age: ..... Occupation: .....
His Annual income .....
17. Insurance on husband's life:

Company	Pol. No.	Amount	Year Issued
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Give details here if any answer to above questions is "Yes"
.....
.....
.....

If applicant is not permanently resident in your territory state his address in home country. .....
.....

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.

Dated at..... this..... day of..... 201 .....
(Village/City & District) (Date)

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

I have carefully reviewed this application and confirm that it has my approval for consideration by the company.

.....	.....
Signature of Unit Manager	Signature of Agency Manager

*Please check if supplementary Report is required on account of sums insured

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Premium Calculation:

Basic Plan ..... Face Amount ..... Mode of Premium Payment: .....

Basic Premium		Rs.		Rs.	
Policy Factor	Rs.			Rs.	
Extra Premium	Rs.			Rs.	
WP	Rs.			Rs.	
ADB	Rs.			Rs.	
PA	Rs.			Rs.	
AX/AI	Rs.			Rs.	
MIB	Rs.	P.M		Rs.	
Other(s)	Rs.			Rs.	
			Total:	Rs.	

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NEPAL OFFICE:
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Kathmandu, Nepal.

DECLARATION

Forming an integral part of the "Application" No .....

In applying for insurance coverage as indicated in the Application and in signing this Declaration, the applicant(s) certify(ies) that the applicant(s) and any designated beneficiary(ies) ARE/ARE NOT[1] United States Persons for United States ("U.S") Federal Income Tax purposes.[2,3] The applicant(s) agree(s) to inform the Company within thirty (30) days of the applicant(s) knowledge of such change if the applicant(s) or any designated beneficiary become(s) a U.S. Person for U.S. Federal Income Tax purposes or if the applicant(s) assign(s) the policy to such a U.S. Person. Please note that a false statement or misrepresentation of tax status by a U.S. Person could lead to penalties under U.S. law.

U.S. Tax ID Number of applicant(s) .....

U.S. Tax ID Number of beneficiary(ies) .....

IMPORTANT: BEFORE SIGNING THIS DECLARATION PLEASE CHECK THAT THE ANSWERS GIVEN ABOVE ARE CORRECT. AN INCORRECT ANSWER MAY INVALIDATE THE POLICY.

Dated at ..... (Village/City & District)

..... (Date)

..... Signature of Proposed Insured

..... Full Name (in own handwriting)

Witness ..... Signature of Agent

..... Signature of Owner if other than Propsed Insured

..... Full Name (in own handwriting)

1. Strike off the term that does not apply.
2. This question is for U.S. Federal Income Tax purposes. The U.S. Internal Revenue Service requires the Company to report to it taxable income paid to persons subject to United States Federal Income Tax. **PLEASE NOTE** that if you are a U.S. person for U.S. tax purposes and fail to provide a U.S. Tax Identification Number to the Company, the IRS requires the Company to withhold tax from taxable income payments made to you at the rate of 31%.
3. For purposes of this declaration a U.S. Person is a citizen or resident of the United States, a United States partnership and any trust which is controlled by one or more U.S. persons and is subject to the supervision of a U.S. court.