American Life Insurance Company
(Incorporated in USA, Nepal Regn. No. 6/062/063)
Narayani Complex, Pulchowk
G.P.O Box: 11590, Kathmandu, Nepal
Tel: +977-1-5555166, Fax: +977-1-5555173
E-Mail: service-nepal@metlife.com.np
Web: www.metlife.com.np

GROUP MEDICAL CLAIM FORM

(A) EMPLOYEE'S SECTION (Please use BLOCK LETTERS)

1. Employee's Name/ Date of Birth : _____
2. Patient's Name / Relation with Employee: _____
3. Group Policy No: _____
4. Employer's Name: _____
5. Nature of Sickness/ Accident: _____

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true. I hereby authorize any doctor, hospital, clinic or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and / or any of my family members to provide American Life Insurance Company with the complete information, including copies of their record with reference to any sickness or accident, any treatment examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy. I also authorize the Company to deposit the payable claim amount in my below mentioned bank account.

1) 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 personal ID, history related with health, (collectively Personal Information) while processing insurance claim. 2) I 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 information to any others within or outside Nepal in the course of claims settlement and investigations. 3) If I have any questions concerning Privacy Policy, I will contact MetLife offices in Nepal.

Bank: _____ Account No.: _____

Employee's Signature: _____ Date: _____

Mobile No: _____

(B) EMPLOYER'S SECTION

1. Coverage Effective Date: _____
2. Number of treatment papers attached: _____
3. Number of bills attached: _____
4. Total Amount Claimed: _____
5. Employer email ID: _____

FOR ACCIDENTAL BENEFIT ONLY (ACCIDENTAL WEEKLY INCOME)

1. Date of Accident _____ Time of Accident _____
2. When was insured compelled to give up his/her duties? _____
3. When did insured returned to work? _____

I hereby certify that all answers and all documents submitted with the Claim Form are complete and true.

Employer's Representative Name: _____

Employer's Representative Signature: _____

Employer's Stamp: _____ Date: _____