MetLife®

CLAIM FORM

- ☐ **DEATH**
- ☐ **CRITICAL ILLNESS**
- ☐ **TOTAL/PARTIAL, PERMANENT/TEMPORARY DISABILITY**
- ☐ **HOSPITAL AND/OR SURGICAL BENEFITS**
- ☐ **MEDICAL EXPENSES**
- ☐ **OTHERS**

I. IDENTIFICATION OF POLICY HOLDER/INSURED PERSON:

Name and Surname of the Insured .....

Personal Identification No. of the Insured .....

Nationality: ..... , Other nationalities: .....

Are you a U.S. CITIZEN? ☐ Yes ☐ No Are you a U.S. Green card holder? ☐ Yes ☐ No

Are you resident in the U.S.? ☐ Yes ☐ No Are you a U.S. Taxpayer? ☐ Yes ☐ No (Tax# .....)

Occupation of the Insured: ..... Occupation of Policy Owner when Died: .....

E-mail address: ..... , Phone No: .....

Home address: .....

Work Address: .....

II. IDENTIFICATION OF THE CONTRACT:

☐ Life Policy# ..... ☐ Accident Policy# .....

III. INFORMATION REGARDING THE EVENT:

Date: / / Place: .....

Cause: ☐ Sickness ☐ Accident ☐ Other

1. In case of accidental injury / Accidental Death:

- Please reveal the circumstances in which it took place, the names of the witnesses, and what were the effects (type of injury, details)

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2. In case of sicknesses / sickness Death:

- Please specify details and the date of appearance of the first symptoms

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- Indicate the first medical examination date related to the event: / /

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- Provide the name, address and the telephone number of the doctors who treated you:

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- In case of hospitalization, Please specify the period: From: / / , to: / /
- State the name and address of the hospital: .....
- Provide the name, the address and the telephone number of the treating doctors .....

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- What other illnesses & injuries have you suffered in the past years? .....

(Mention and specify the date, the name, the address and the telephone number of the doctors who have treated you):

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IV. BENEFITS PAYMENT:

In case of payment decision for this claim, the payable amount will be transferred directly into the beneficiary's bank account based on the following information:

INSURED / BENEFICIARY

Name and Surname .....

Identity Card: ..... (Personal Number Code) or (Entity registration no.): .....

Into account no. .....

Opened at (Bank Name) ..... , Branch .....

Account Holder* (name and surname) .....

I, ..., the undersigned as Insured/beneficiary, hereby declare that I agree with the payment of the claim benefit, in the above account and that the information submitted above is correct. In case of inaccurate or incomplete data I understand and accept that MetLife cannot be held responsible for the transfer of the payable amount into wrong account. Therewith I accept that any process needed in order to recover the amount shall be done by me, with no responsibility of any kind on MetLife.

V. RECEIPT AND RELEASE

"Upon receiving the Amount from MetLife, I unconditionally, fully and conclusively, release and forever discharge MetLife, its affiliated companies and branches of their respective officers, directors, agents, representatives, parent companies and attorneys of and from any and all claims, demands, benefits, compensation or amounts arising directly or indirectly from the Policy or any claims known or unknown that I may now have or has ever had against MetLife related to the Policy. I further undertake that I shall not, now or in the future, sue or purport to sue MetLife claiming for any further amounts, damages, compensations, costs, charges, expenses, interests, costs or legal fees under to the Policy."

VI. DISCLAIMERS & CLARIFICATIONS

I, ..., the undersigned, hereby agree with the following:

Data Clarification: I hereby clarify that the foregoing answers are true and correct to the best of my knowledge and agree that the written statements and affidavits of all who attended to or treated me / the insured shall constitute and they are hereby made a part of the proof of claim / death, and agree that the furnishing of these forms, or of any other forms supplemental thereto, by said company shall not constitute nor be considered by it that there was any insurance in force on the life in question, nor a waiver of any of its rights defences. I agree and understand that the lapsed / expired or cancelled of the above mentioned policies has no effect legally and materially and i hereby discharge MetLife generally, finally, conclusively from any liability or obligationunder these policies.

Authorization for Medical information requested by the Insurance Company I hereby authorize all physicians, hospitals, clinics, pharmacists, laboratories, employers and any institution or any other person who ever treated me or has any record of information refering to my health condition to provide MetLife insurance company with full information (including full copies of my records) regarding this claim.
Any copy of this authorization shall be taken as the original copy.

Privacy & Cross Border: I hereby provides the Company, its officers, employees and representatives (the "Company Representatives"), his/her unambiguous consent to collect, process, share, store, use, disclose and transfer his/her personal data directly or indirectly to a recipient inside or outside Jordan for the purpose of fulfilling any obligation imposed on the Company inside or outside Jordan, where such collection, processing, sharing, storing, usage, disclosure and transfer, is necessary for the performance of the contract of insurance and/or for the purpose of compliance with any legal or contractual obligation to which the Company or any of its subsidiaries or affiliates is subject to inside or outside Jordan. I also authorizes the Company to obtain from and share with any source inside or outside Jordan as it deems appropriate, information concerning his/her or any member of his/her family, financial and / or professional and / or personal status for the purpose of applying the provisions of the insurance policy and collection of premium related to his/her insurance policy or policies and/or for the purpose of complying with its legal or contractual obligations in Jordan or outside Jordan. **International and Local Sanction and Exclusion Clause:** I understand that Coverage and/or Payment under the insurance contract will NOT be made if: (i) the policyholder, insured, or person entitled to receive such payment is residing in a sanctioned country; or (ii) the policyholder, the insured or person entitled to receive such payment is listed on the Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) list, the OFAC Sectorial Sanctions Identifications list or any international or local sanctions list; or (iii) the payment is claimed for services received in any sanctioned country. I also understand that the Company shall not be liable to pay any claim or provide any coverage or Benefit to the extent that the provision of such coverage or Benefit would expose the Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America or any other applicable laws. **Foreign Account Tax Compliance Act (FATCA) Declaration:** I hereby acknowledges, understands and agrees that for the purpose of the Foreign Account Tax Compliance Act (FATCA) – an American law designed to identify U.S. ownership of financial accounts at non- U.S. financial institutions, including non - U.S. funds – hereby authorize the Company, (together with its officers, employees, agents), in his/her capacity as an Insurance Policy account holder with the Company, to proceed to the processing and transferring to the U.S. IRS (Internal Revenue Service in the U.S.A.), of his/her personal data, including his/her name, address, tax identification number / social security number and account balance / activity with the Company, upon receipt of an official request from the U.S. IRS in this respect. Consequently, The Policy Owner/Insured waives his/her right to confidentiality with regard to the above information and any other personal information which may be disclosed by the Company in order to comply with FATCA requirements. The Policy Owner/Insured agrees to release and hold harmless the Company (together with its officers, employees, agents) from any and all claims or actions or damages of any kind arising from, or in any way connected to, the release and/ or use of the above information pursuant to this waiver. The Policy Owner/Insured would be grateful if the Company could keep him/her informed about his/her personal data and/or any information disclosed to the U.S. IRS in accordance with the terms of this waiver. The Policy Owner/Insured further acknowledge and agree that the Company will deduct any withholding required by the US Foreign Account Tax Compliance Act ("FATCA"). The Policy Owner/Insured hereby acknowledge, understand and agree that the Company reserves the right, within its sole discretion, to terminate his/her Insurance Policy in the event that the appropriate documentation of his/her US or non-US status for purposes of FATCA is not timely provided to the Company. In particular, in the event that applicable laws or regulations of Jordan would prohibit withholding on payments to the account or prohibit the reporting of the account, and no waiver of such local law is obtained, the Company reserves the right to close the account and terminate the Insurance Policy or decline my claim. **SMS:** I hereby authorize the company to use my cell phone number mentioned in (Section I - personal statements) of this Application to deliver information or data related to my insurance policy / policies throughout Metlife SMS service (SMS). I also agree to inform the company in writing in the event of disconnection or change to my cell phone number that receives this service or loss or theft of cell phone card to enable the company to modify or stop the Service. I understand that the company will make sure that when sending and receiving this data / information and will take appropriate precautions to ensure the security, integrity and privacy of personal data to the client. I agree to receive all messages sent to me from the company on the cell phone number specified in the application and to consider all the messages sent in this manner has been delivered to me under my full responsibility from the moment they were sent. I also agree with and understand that the company will not hold any responsibility for any damages or losses, costs or expenses incurred due to fraud or theft, or improper use or unauthorized access to personal information about the insurance policy while transferring data / information through SMS. The Company does not take any responsibility for the delay in delivery or non-delivery of the message because of a defect or a technical failure in the network for any reason.

..... **Date :** ..... / ..... /..... .....

Name & Signature of the Insured / Beneficiary **Name & Signature of the Wetness**