Medical Claim Reimbursement Form

MetLife Alico℠

American Life Insurance Company
WILMINGTON, DELAWARE, U.S.A., INCORPORATED 1921

ADMINISTRATIVE OFFICE
P.O. Box 371916, Dubai, United Arab Emirates

EMPLOYEE'S SECTION (*All Fields are Mandatory)

Employees's Full Name* ______ Date of Birth D D M M Y Y Y Y

Patient's Full Name* ______ Date of Birth D D M M Y Y Y Y

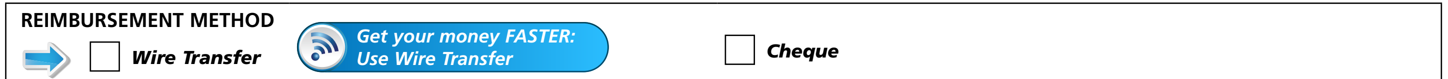
Employee's Nationality* ______ Patient's Nationality* ______

Employee Contact No.* Country Code – Area Code – ______

Policy Number* *(Mentioned on your Medical Card)* ______ Certificate Number* *(Mentioned on your Medical Card)* ______

Employee E-mail Address.* ______

Address* ______



Primary Insured's Bank Name* & Swift Code* *(If not using IBAN)* Bank's Name | Swift Code

IBAN / Account No.* *(Bahrain, Kuwait, Qatar and UAE - Provide IBAN for Wire Transfer)* IBAN / Account No.

Payment made in the name of ☐ Employee ☐ Employer Group ☐ Assigned Provider

Total Amount Claimed ______ Currency ______

EMPLOYER'S SECTION

Employer's Claim No. ______

Employer's Signature & Stamp ______

CLAIM SUBMISSION REQUIREMENTS

To avoid any delays in the processing of your claim, please ensure that:

1. All fields on the form should be answered. Do not leave any blanks. Use block letters.
2. All original claim documents should be submitted either in English or Arabic. Documents in other languages must be translated by an official public translator prior to submission.
3. All necessary original claims documents are to be submitted within 30 days of the incurred date. Claims received after 90 days will not be processed.

The following original documents are to be attached:

Out Patient Treatment

1. Official receipt showing the attending physician's detailed charges along with his stamp and signature.
2. Itemized pharmacy bill showing the date of purchase, name of patient, quantity and name of drugs along with the physician's prescription.
3. Official receipt showing charges for each of the Lab Test, X-ray films, and other examinations done and supported by the respective physician's request to undergo examinations and copies of the results of examinations undertaken.

In-Patient Treatment

1. Itemized hospital bill supported by the official hospital receipt for the total amount paid.
2. Official receipt showing Attending Physician's or Surgeon's charges along with his stamp and signature.
3. Detailed hospital discharge report.

AUTHORIZATION STATEMENT

I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, 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 Metlife Alico (American Life Insurance Company) with the complete information's, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

DISCLAIMER

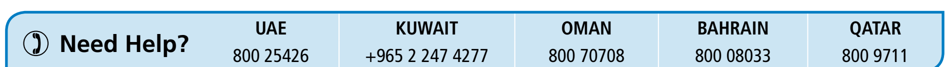
I hereby authorize Metlife Alico to wire transfer claim reimbursements to the account indicated above. This agreement will remain in effect until I give written notice to withdraw from wire transfer or Metlife Alico notifies me that this service has been terminated. If ever Metlife Alico credits more money than the correct benefit amount to the account due to duplicate or erroneous electronic funds transfers, I authorize Metlife Alico to revise the Transaction and withdraw the overpayment.

Metlife Alico will bear charges on account of claims reimbursement levied by the remitting bank. All charges that may be levied by the beneficiary's bank / other third-party provider will be borne by the beneficiary. We suggest confirming these charges, if any, with your banking provider".

I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company. I also accept and recognize that at the sole discretion of the MetLife Alico, these documents may be requested at any time during a period of one year counted from the submission of the claim, which I will provide within a period not exceeding of 30 days from the request. Failing to comply could imply the claim to be declined. If the case is confirmed to be declined, I will reimburse any amount paid by MetLife Alico to me or to any party as related to this claim.

i hereby understand no coverage and / or payment under the Policy and/or any supplementary contract (if any) will be provided / made if the person entitled to receive such payment is (i) residing in any sanctioned country, or (ii) is listed on the Office of Foreign Asset Control (OFAC) Specially Designed Nationals (SDN) list or any international or local sanction list, (iii) the payment is claimed for any services received in any sanctioned country, subject to the Policy and / or Supplementary contract terms and conditions.

Employee's Signature ______ Date D D M M Y Y Y Y



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ATTENDING PHYSICIAN SECTION (*Mandatory Fields)

Patient's Full Name ______________________ **Date of Birth** D D M M Y Y Y Y

Chief Complains*

Diagnosis*

How long has the patient been suffering from this sickness?*

Please specify the date symptoms first appeared.

If treated by other medical provider please specify the name and treatment details

If the claim is resulting from pregnancy / childbirth, please provide the LMP*

Details of the treatment (other than Prescription)

If further treatment or operative procedure anticipated, please provide the details

Physician's Name, Address and Tel. No.

Physician's Signature and Stamp

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