MetLife

Recovery Benefit Plan
Claim Form

Policy No. .....

Part A . Insured's Statemenrt

Name of Insured .....

Insured's Address :

Street ..... P.O.Box .....

City ..... Country .....

1. Nature of Disease .....

2. Date of First Consultation .....

3. Date of Diagnosis of Disease .....

4. Has disease been caused by :

   a. Acquired Immune Deficiency (AIDS) ? .....

   b. Misuse of drugs or alcohol ? .....

5. Cardiac Bypass Surgery (if applicable)

   a. Date of surgery .....

   b. No of coronary arteries involved .....

6. a. Name of Treating Physician .....

   b. Physician's address .....

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Authorization

I hereby authorize all doctors or other persons and all hospitals or other institutions to furnish all information (including full copies of their records) regarding myself, my medical history in general and this claim in particular to MetLife Alico (american life insurance company).

A photocopy of this authorization shall be considered as Original.

Signature of Insured ..... Date .....

Complete for Diagnosed Disease

1. Date you were first consulted for the symptoms of this condition :

   Month ..... Day ..... Year .....

2. Date patient had previous medical attention for this condition :

   Month ..... Day ..... Year .....

   Physician .....

   Address : Street ..... City .....

3. Date confined to Hospital :

   From : ..... To : .....

   From : ..... To : .....

4. Hospital Name .....

   Address .....

5. Has disease been caused by : (Give Details)

   a. Acquired Immune Deficiency Disease virus (HIV). Or is it an AIDS related complex of infection by HIV virus ?

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   b. Misuse of Drugs or Alcohol ?

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   .....

Name of Attending Physician .....

Hospital or clinic address .....

Signature ..... Date .....

Part B - Physician's Statement

Name of Patient ..... Date of Birth .....

Height ..... Weight .....

1. **Complete for Myocardial Information:**

   a. Final diagnosis .....

   .....

   b. Date of Diagnosis .....

   c. Was there history of chest pain ? Yes ..... No .....
   If yes. give details.

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   d. Did EKG reveal new Electrocardiographic changes ? Yes ..... No .....
   If yes. give details.

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   e. Was there elevation of Cardiac Enzymes ? Yes ..... No .....

   (Company requires all laboratory tests. EKGS and X-RAYS done)

2. COMPLETE FOR CORONARY ARTERY DISEASE REQUIRING SURGERY

   a. Date of Diagnosis .....

   b. Nature of Surgery .....

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   c. Date of Surgery .....

   d. No of coronary Arteries involved .....

   (Company requires all laboratory tests, EKGS and Catheterization Film & Diagram)

3. **Complete for Cerebral Stroke :**

   a. Final Diagnosis .....

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   b. Date of Diagnosis .....

   c. Did EEG reveal permanent neurological deficit ? .....

   (Company requires all laboratory tests. EEGS and Neurologist Opinion Confirming diagnosis)

4. **Complete for Cancer :**

a. Detailed final diagnosis including location .....

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b. Date of Diagnosis .....

c. Medical History .....

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(Company requires all laboratory and Tissue Biopsy Pathology Tests)

*** 5. Complete for Chronic, IrreversibleRenal Failure :**

a. Detailed Diagnosis .....

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b. Date of Diagnosis .....

c. Medical History .....

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d. Nature of Treatment .....

(Company requires all laboratory Tests)

*** 6. Complete for Blindness caused by Sickness :**

a. Nature of sickness .....

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b. Is blindness total, permanent and irrevocable ? Yes ..... No .....

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c. Date of Diagnosis .....

d. Medical History .....

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(Company requires all laboratory Tests)
*Applicable to RBP contracts issued in december 1990 and later