MetLife

Claimant's Statement (Total Disability Benefits)

This statement must be fully answered by the insured or his duly appointed Guardian or Committee, insane, due to physical condition, Insured is unable to answer thes questions beneficiary or nearest relative may do so

1- Full name of Insured	2- Occupation (state exact duties full)
3- (a) Date of insured's birth (Month) (Day) (Year)	4- Height ..... Weight ..... Feet Inches Pounds
5- Describe fully Insured's present condition	6- To what extent is Insured unable to follow any occupation?
7- Give date of injury or beginning of illness causing present condition (Month) (Day) (Year)	8- When was Insured compelled to give up part of this duties? (Month) (Day) (Year)
9- When, was Insured compelled to give up all of his duties? (Give exact date) (Month) (Day) (Year)	10- How does Insured spend his time?
11- Has Insured done any kind of work since commencement of disability? If so, give particulars.	12- When does insured expect to return to work?

13- Give name and address of every physician who attended or practitioner prescribed for Insured during present affliction.

a- Durarion	b- Name of physician or practitioner	c- Address
From ..... To ..... From ..... To ..... From ..... To ..... From ..... To		

14- For What disease, injury ailment or affliction has Insured requred the services of physician or practitioner proir to present affliction.

a- Name of injury, disease, etc.	b- Durarion	c- Name of physician or practitioner	d- Address
	From ..... To ..... From ..... To ..... From ..... To ..... From ..... To		

15- Has either of Insured's parents or any of this brothers or sisters or other relative been afflicted with a similar disease? If so give particulars	16- Is Insured's estate represented by a committee or guardain? (If so, furnish copy of appointment)

17- What other life, Government. Health or Accident Insurance providing for disability benefits, have you?

a- Name of Company	b- Address	c- Amount of weekly or monthly indemnity?

I hereby authorize any hospital to which I have been confined and any physician or who has treated, is now treating me.to impart to MetLife any information it may desire.

Signature of insured .....

Residence .....

No. Street City State