MetLife

CLAIMANT'S STATEMENT

PROOFS OF DEATH

Submitted to

METLIFE, LIFE INSURANCE COMPANY

Number of Policies in this Company	Amounts

Deceased's name in full ---------- If a married woman state maiden name also ---------- Age ----------

I. Occupation at date of death? ----------

2. a. Date and place of deceased 's birth ?
b. Source from which date of birth obtained? (Family record or any Other record or certificate of (birth should be referred to).
a. Date ---------- Place ----------
b. ----------

3. a. Date and place of death?
b. Cause of death?
a. Date ---------- Place ----------
b. ----------

.When did deceased tint complain of, or give other indications of his last illness? Date ----------

4. b. When did deceased tint consult a physician for his last illness ?Date ----------

5 .On what dale did deceased last attend to his usual work? Date ----------

6.a. Name and addresses of all physicians who attended to deceased during his last illness and during five years prior thereto :

Name	Address	Date of Attendance	Disease or Condition

b. Had the deceased within the last five years been an inmate of ,or under treatment 11a hospital ,sanitarium, asylum, or Other institution? ----------
(If so, state when, where and for what cause?) ----------

7. In what other companies, and for what amounts, was the life of deceased insured?

Company	Policy Number	Policy Date	Amount of Insurance

8.In what capacity, or by what title, do you claim Ibis Insurance ? ----------

9.Did you elect one of the optional modes of settlement\ in lieu of an immediate cash payment? ----------
If so, which mode of settlement? ----------

10. What is your dale of birth? ----------

The undersigned ,hereby makes claim to said insurance, and agrees that the written statements and affidavits of all the physicians who attended to or treated the insured shall constitute and they are hereby made a part of these Proofs of Death, and further agrees that thefurnishing of this form, 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 of the life in question, nor a waiver of any of its rights or defences.

Dated at ---------- Signature ----------
(city) *(country)*

This ---------- day of ---------- 20 ---------- Address ---------- (P.O. Box) ----------
On this ---------- day of ---------- 20---------- personally appeared before me the above named ---------- who is known to me and subscribed the foregoing statement before me.

AUTHORIZATION

"The undersigned hereby authorizes all physicians. hospitals ,clinics, pharmacists ,laboratories, employers and any institution or any other Person who has any record or information on ---------- (deceased) to Provide (MetLife, Life Insurance Company) any and all information with respect to medical history , consultation , prescription or treatments and copies of all hospital or medical or records . Any copy of this authorization shall be taken as the original copy".

Name ---------- Signed ---------- Date ----------

Witness---------- Signed ---------- Date ----------